

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2339

## CERTIFICATE OF DEATH

Reg. Dist. No. 12258

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE DIST. OF COLUMBIA COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENN DALE	c. LENGTH OF STAY IN 1b 13 MOS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	d. STREET ADDRESS 1449 OAK ST. N.W.
d. NAME OF HOSPITAL (If not in hospital, give street address) GLENN DALE HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VALANDA	First J. Middle Last	4. DATE OF DEATH ADAMS	Month 2 / Day 8 Year 1958
S. SEX F	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/20
9. AGE (In years lost birthday) 37 yrs.		10. IF UNDER 1 YEAR Months 2 Days 8 Hours 0 Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAR MAID		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	11. BIRTHPLACE (State or foreign country) CONN.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME MOSES G. JOHNSON	
14. MOTHER'S MAIDEN NAME JOSEPHINE BONACHIE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 578-10-1838		17. INFORMANT DECEDENT	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY TUBERCULOSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 DAYS 13 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	Month Day Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____		1/30, 1958, to 2/8, 1958, that I last saw the deceased alive on 2/8, 1958, and that death occurred at 7:30 A.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Moe Weiss	M.D.	ADDRESS (Street, city or town, state) GLENN DALE HOSP. DATE SIGNED GLENN DALE, MD 2/8/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 11, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Lincoln Cemetery	22d. LOCATION (City, town, or county) Sutherland Rd
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Co - 1432 - You do		24a. REC'D BY REGISTRAR DATE FEB 11 '58	24b. REGISTRAR'S SIGNATURE John L. Smith

MISSOURI STATE DEPARTMENT OF HEALTH - DIVISION OF

CERTIFICATE OF DEATH

BUREAU V. S.  
RECEIVED

FEB 11 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02259

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be filed as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		2282										2	
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
		b. STATE Maryland											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 16		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
Prince Georges		MARYLAND		34 Brentwood		Prince Georges							
Cheverly		36 days		d. STREET ADDRESS		4000 38th Street, Apt. 4							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)													
Prince Georges General Hospital													
3. NAME OF DECEASED (Type or print)		First Annie		Middle Carroll		Last Aman		4. DATE OF DEATH		Month February 19		Year 1958	
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 4-12-75		9. AGE (In years from birthday) 82 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Housewife				Washington, D.C.		U.S.A.							
13. FATHER'S NAME Robert Lee Carroll		14. MOTHER'S MAIDEN NAME Catherine Lewis											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. No.		17. INFORMANT none		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9040		DUE TO		Acute cardiac failure				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO		Fracture of left hip				260 Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fall in home											
20c. TIME OF INJURY Month, Day, Year Hour 11.00 p.m. 1-13-58		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Brentwood, Pr. Geo. Md.		(County)		(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED February 19, 1957							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/21/1958		22c. NAME OF CEMETERY OR CREMATORIUM Glenwood Cemetery		22d. LOCATION (City, town, or county) Washington, D.C.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Nally's Funeral Home		ADDRESS Mt. Rainier, Md.		24a. REC'D BY REGISTRAR FEB 24 '58		24b. REGISTRAR'S SIGNATURE W. L. Deuch							

RECEIVED  
FEB 24 1958

FEB 24 1958

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2283

## CERTIFICATE OF DEATH

Reg. Dist. No.

(12260)

1. PLACE OF DEATH a. COUNTY <i>Prince George Co.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) <i>Riverdale Md.</i>		c. LENGTH OF STAY IN 1b <i>30 hours 14</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Leland Memorial Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <i>9725 51st ave</i>		
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Baby (Newborn) Boy</i>	Middle	Last <i>Anderson</i>	
4. DATE OF DEATH	Month <i>Feb.</i>	Day <i>16</i>	Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 14, 1958</i>	
9. AGE (In years last birthday) <i>30-4 hrs</i>	10. IF UNDER 1 YEAR Months <i>30</i>	11. IF UNDER 24 HRS. Days <i>4</i>	12. Hours <i>30</i>	
13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>MD.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Mr. James Richard Anderson</i>	14. MOTHER'S MAIDEN NAME <i>Joy Worstall</i>	Address <i>Leland Memorial Hosp. 1</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>762.5</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Nurse</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), or (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Affectionate prematernity</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <i>11/2 days</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year <i>1958</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Riverdale</i>	(County) <i>Md.</i>	
21. I certify that I attended the deceased from <i>762.5</i> , 1958, to <i>Feb 16 1958</i> that I last saw the deceased alive on <i>Feb 15</i> , 1958, and that death occurred at <i>619</i> M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>L W Malin</i> M.D. PHYSICIAN'S NAME (Type) <i>L W Malin</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/18/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Evergreen Cemetery</i>	22d. LOCATION (City, town, or county) <i>Baldensburg Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons Hyattsville, Md.</i>		24a. REC'D BY REGISTRAR <i>Feb 20 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Al. Seach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from page 3 and be retained for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CONFIDENTIAL - SECURITY INFORMATION

BUREAU V.

FEB 20 1959

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2284 CERTIFICATE OF DEATH**

(12261)

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>20 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Johns Hopkins Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14. <i>College Park</i>	
3. NAME OF DECEASED (Type or print) <i>John W. Raymond Archer</i>		d. STREET ADDRESS <i>9120-49th Ave</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 2, 1890-</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>	
11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Q. Archer</i>		14. MOTHER'S MAIDEN NAME <i>Virginia Barnes</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Mona Lee Archer</i>	
17. INFORMANT <i>College Park, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Arterio-sclerotic heart dis</i>			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>4713-Bargy St</i>		20f. (City or town) (County) <i>College Park</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>JAN 27, 1958</i> , to <i>JAN 31, 1958</i> , that I last saw the deceased alive on <i>JAN 31, 1958</i> , and that death occurred at <i>12:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W.L. ETIENNE</i>		ADDRESS (Street, city or town, state) <i>4713-Bargy St</i> (Date Signed) <i>1/2/58</i>	
PHYSICIAN'S NAME (Type) <i>W.L. ETIENNE</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Transportation</i>		22b. DATE THEREOF <i>Feb 3, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Huntington</i>		22d. LOCATION (City, town, or county) <i>West Virginia.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		24a. REC'D BY REGISTRAR <i>DATE 3 '58</i>	
ADDRESS <i>Hyattsville Maryland</i>		24b. REGISTRAR'S SIGNATURE <i>John Lewis</i>	

CERTIFICATE OF DESIGN

BUREAU V. S.

TEB 3 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2285

Items 8,9 Film G225 2-26-58 et

12262

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH

a. COUNTY

Prince George

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb  
RURAL and give nearest town)

7 days

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

Prince George General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

15 8804 // Hyattsville

Hyattsville

d. STREET ADDRESS

5504 44th Ave

e. IS RESIDENCE  
ON A FARM?YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Elizabeth

Middle

M

Last

Arthur

4. DATE  
OF  
DEATHMonth  
Feb 18

Day

Year  
1958

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED WIDOWED 

8. DATE OF BIRTH

5-7-91 1883

9. AGE (In years  
last birthday)

61 74 yrs.

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Housework

10b. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Costello

14. MOTHER'S MAIDEN NAME

Mary Jane McGovern

Address 304 4th Ave  
Hyattsville Md

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes or unknown)

(If yes, give war or date of service)

16. SOCIAL SECURITY NO.

-

17. INFORMANT

Mrs Joshua W. Webb

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

442X

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

Uremic

INTERVAL BETWEEN  
ONSRT AND DEATH  
week

DUE TO

Nephrosclerosis

year

(c)

Hypertensive cardiovascular disease

year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]

20c. TIME OF INJURY Month, Day, Year  
Hour a. m.  
p. m.20d. INJURY OCCURRED  
While at work  Not while at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Jan 1st, 1957, to Feb. 18, 1958, that I last saw the deceased alive on Feb 18, 1958, and that death occurred at 8:10 AM, from the causes and on the date stated above.

ACTUAL  
SIGNATUREPHYSICIAN'S  
NAME (Type)

Dr. Aron Deitz

M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM 22d. LOCATION (City, town, or county) (State)

Burial

2/24/58

Greenmount Cemetery Greenmount over Oliver St

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS DATE REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

W.H. Chambers Jr. 1400 Chapin St NW

FEB 21 '58 Quincey

RECEIVED  
FEB 21 1968  
BUREAU Y. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2286

## CERTIFICATE OF DEATH

Reg. Dist. No.

112263

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 thru 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 25½ hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital		d. STREET ADDRESS 5502 43rd Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES		First (NMN)	Middle AUSTIN	4. DATE OF DEATH February 16 1958	Month Day Year		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 9/30/74	9. AGE (In years last birthday) 83 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store keeper		10b. KIND OF BUSINESS OR INDUSTRY Ice Cream Store		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer Austin		14. MOTHER'S MAIDEN NAME Rebecca Downs					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO None		17. INFORMANT Unknown		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] - PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>		DUE TO <i>495X</i>		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (c)							
DUE TO <i>Hypertension</i>							
- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>injury due to fall</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 15<sup>th</sup>, 1958</i> to <i>Feb 16<sup>th</sup>, 1958</i> , that I last saw the deceased alive on <i>Feb 16<sup>th</sup>, 1958</i> , and that death occurred at <i>1 PM</i> , from the causes and on the date stated above				ADDRESS (Street, city or town, state) <i>Levittown Manor Hosp 21615</i>		DATE SIGNED <i>2/16/58</i>	
ACTUAL SIGNATURE <i>D R Lurie</i>		M.D. <i>Lester Lurie</i>					
PHYSICIAN'S NAME (Type) <i>D R Lurie</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 19/1958		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county), (State) Colmar Manor, Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W W Chambers Co - Riverdale MD</i>		ADDRESS <i>W W Chambers Co - Riverdale MD</i>		24a. REC'D BY REGISTRAR DATE FEB 20 '58		24b. REGISTRAR'S SIGNATURE <i>Outlook</i>	

BURLEAU V.

1953

EDUCATED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02264

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in full, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained by your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenarden</b>		c. LENGTH OF STAY IN lb <b>4 mo</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Reed Street</b>		e. STREET ADDRESS <b>Reed Street</b>	
3. NAME OF DECEASED (Type or print) <b>Lyndy</b>		4. DATE OF DEATH <b>February 14, 1958</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 5, 1957</b>	
9. AGE (In years last birthday) <b>5 yrs</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
10c. BIRTHPLACE (State or foreign country) <b>Maryland</b>		11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Clarence Bailey</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Burroughs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs Catherine Bailey, same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b>			
DUE TO  Conditions, if any, which gave rise to immediate cause (b) <b>Universal burns of the body</b>			
DUE TO  (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Occupant of a house that caught on fire</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Occupant of a house that caught on fire</b>	
20c. TIME OF INJURY <b>3:00 p.m.</b>		20d. INJURY OCCURRED Month Day Year <b>2/14 1958</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) <b>Home</b>		20f. (City or town) <b>Glenarden</b>	
(County) <b>P. G.</b>		(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  <i>James I. Boyd</i>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL/CREMATION REMOVAL (Specify) <b>Woodlawn</b>		22b. DATE THEREOF <b>2/17/58</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn</b>		22d. LOCATION (City, town, or county) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry &amp; Washington Sons</b>		24a. REC'D BY REGISTRAR <b>Feb 24 '58</b>	
ADDRESS <b>467 N St. NW. Wash. D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Dee L. L.</b>	

BUREAU Y.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

112265

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHA3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be given to the burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH		2341		3. NAME OF DECEASED		Everett Mansfield Barnes		4. DATE OF DEATH		Feb 13 1958	
a. COUNTY		Prince George's MARYLAND		First Middle		Last		Month		Day Year	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Bowie transient		c. LENGTH OF STAY IN 1b		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Wilmington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		1010 Faulk Road		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Bowie Race Track		d. STREET ADDRESS		1010 Faulk Road		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		Everett Mansfield Barnes		5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH	
Male White		WIDOWED		Divorced		Nov 19, 1890		67 yrs		9. AGE IN YEARS (on birthday)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Salesman Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Salesman Retired						Massachusetts		U. S. A.			
13. FATHER'S NAME		William Herrington Barnes		14. MOTHER'S MAIDEN NAME		Harriette Osborne		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
Yes		119-11611-8-16		221-03-6606		Mrs Dorothy Lockerman		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		Acute congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH			
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO		Coronary atherosclerosis					
				(c) DUE TO		Cardiovascular renal disease					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED?			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE  EXAMINER'S NAME (Type)		James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED February 13, 1958	
22b. BURIAL/CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)			
Burial		1-15-58		Gracebury, New. Del.		Newark, Delaware					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Joseph P. Grant		North East Md.		FEB 18 '58		Allie Leach					
VS. A15ME											
SM 2 57											

BULLEAU V. 2

FEB 18 1970



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2287 CERTIFICATE OF DEATH**

Reg. Dist. No.

02266

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rivendale</b>		b. COUNTY <b>Prince Georges</b>	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eugene Island Memorial Hospital</b>		d. STREET ADDRESS <b>11706 Montgomery Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Eugene</b>	Middle -	Last <b>Bobbitt</b>
4. DATE OF DEATH	Month <b>February</b>	Day <b>21</b>	Year <b>1958</b>
5. SEX	6. COLOR OR RACE <b>Male</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-28-06</b>
9. AGE (In years last birthday) <b>51 yrs</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>US Govt. Bethesda Research Center</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Bobbitt</b>		14. MOTHER'S MAIDEN NAME <b>Maude Edwards</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
Address <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
<b>Pulmonary hemorrhage -</b>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <b>Pulmonary edectasis (left lung)</b>			
DUE TO			
(c) <b>Massive Infarction of liver - Sclerosis arteriana</b>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-31, 1957</b> , to <b>2-21, 1958</b> , that I last saw the deceased alive on <b>2-21, 1958</b> , and that death occurred at <b>9:50 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>D.R. Purdie</b>		M.D. ADDRESS (Street, city or town, state) <b>4404 GREENSBURG Rd</b>	
PHYSICIAN'S NAME (Type) <b>DR PURDIE</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Oct 23, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Zion Cem.</b>	
22d. LOCATION (City, town or county) <b>Highland Md</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Montgomery Funeral</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>FEB 25 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Abraham</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUKEAU V. E

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2342

## CERTIFICATE OF DEATH

112267

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brentwood Md</i>		c. LENGTH OF STAY IN 1b <i>1 yr</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brentwood Md</i>	
d. STREET ADDRESS <i>—</i>		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth Hayes</i>	First <i>Elizabeth</i>	Middle <i>Hayes</i>	Last <i>Brown</i>
4. DATE OF DEATH <i>July 13, 1880</i>	Month <i>July</i>	Day <i>13</i>	Year <i>1880</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 13, 1880</i>
9. AGE (In years last birthday) <i>77 1/2 yrs.</i>	10. IF UNDER 1 YEAR Months <i>—</i>	11. IF UNDER 24 HRS. Days <i>—</i>	12. IF UNDER 24 HRS. Hours <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Millboro - VA.</i>	12. CITIZEN OF WHAT COUNTRY? <i>—</i>
13. FATHER'S NAME <i>Andrew J. McCay</i>	14. MOTHER'S MAIDEN NAME <i>Virginia — UNKNOWN</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs Vella S Wilson</i>	Address <i>1522 Foyle Rd New</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>			
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Congestive Heart Disease</i>			
DUE TO (c) <i>—</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
p. m. <i>—</i>		<i>—</i>	<i>—</i>
21. I certify that I attended the deceased from <i>Baltimore, 1957</i> , to <i>Baltimore, 1958</i> , that I last saw the deceased alive on <i>2-15 1958</i> , and that death occurred at <i>6:00 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Russell S Wilson</i>		ADDRESS (Street, city or town, state) <i>5 Brentwood Md 2-15-58</i>	
PHYSICIAN'S NAME (Type) <i>Richard J. Hobson</i>		DATE SIGNED <i>—</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-22-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Lincoln</i>	22d. LOCATION (City, town, or county) (State) <i>Edgar Manor Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Lee Wash. D.C.</i>		24a. REC'D BY REGISTRAR <i>—</i>	24b. REGISTRAR'S SIGNATURE <i>—</i>
ADDRESS <i>—</i>		DATE <i>—</i>	DATE <i>—</i>

BURKAU Y.

EEB 24 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

112268

## 2265 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince Georges' Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College PK</i>	c. LENGTH OF STAY IN 1b <i>12 years</i>	b. COUNTY <i>Prince Georges</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College PK</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4719 Muskogee St</i>	e. STREET ADDRESS <i>4719 Muskogee St</i>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>WALTER STANISLAUS Brown</i>	First <i>WALTER</i>	Middle <i>STANISLAUS</i>	Last <i>Brown</i>
4. DATE OF DEATH <i>Feb</i>	Month <i>Feb</i>	Day <i>20</i>	Year <i>1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 10 1876</i>
9. AGE (In years last birthday) <i>88 yrs.</i>	10. IF UNDER 1 YEAR Months <i>8</i>	11. IF UNDER 24 HRS Days <i>Hours</i>	12. IF UNDER 24 HRS Min. <i>Min.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auto Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>MASS.</i>	
11. BIRTHPLACE (State or foreign country) <i>MASS.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>ZACHARIAH Brown</i>		14. MOTHER'S MAIDEN NAME <i>Bedilia Hart</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>USA</i>		16. SOCIAL SECURITY NO. <i>WIFE MRS Blanche Brown</i>	
17. INFORMANT <i>Address</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Arteriosclerotic Heart Disease</i>		DUE TO <i>2 yrs</i>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 1, 1957</i> to <i>Feb 22, 1958</i> that I last saw the deceased alive on <i>Feb 20, 1958</i> , and that death occurred at <i>1030 Perry St</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Norman Donat (Bmeau</i> PHYSICIAN'S NAME (Type) <i>Norman Donat (Bmeau</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/25/58</i>	
22c. NAME OF CEMETERY OR CEMETRATORY <i>Arlington National</i>		22d. LOCATION (City, town, or county) <i>Arlington Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons Hyattsville, Maryland.</i>		24a. REC'D BY REGISTRAR <i>Febr 24 '58</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Elaine Lee</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 24 1953

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02269

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	c. LENGTH OF STAY IN TB <b>Dead on arrival</b> X Lanham				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>	e. STREET ADDRESS <b>9302 Tuckerman Street</b>				
3. NAME OF DECEASED (Type or print) <b>Franklin John Bruzbart</b>	First Middle Lost DATE OF DEATH Month Day Year <b>February 16 1958</b>				
4. SEX <b>Male</b> COLOR OR RACE <b>White</b>	5. MARRIED NEVER MARRIED DIVORCED WIDOWED <b>12/2/1910</b>	6. AGE (In years last birthday) <b>47 yrs.</b>	7. IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Personal Service Mgr.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>American Auto Assn</b>	11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Peter Bruzbart</b>	14. MOTHER'S MAIDEN NAME <b>M argaret Levanovich</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>578-03-2485</b>	17. INFORMANT <b>Mrs Dorothy Bruzbart</b> , same as # 2	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>442 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Acute congestive heart failure</b> (a), stating the underlying cause lost. (c) <b>Cardiovascular renal disease</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month Day, Year Hour o m p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James I. Boyd</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <b>February 16, 1958</b>	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>19 Feb. 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Ft. Lincoln Cem.</b>	22d. LOCATION (City, town, or county) <b>Bethesda - Md</b>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home 44 May Ave N.E.</b>	ADDRESS <b>Washington D.C.</b>	24a. REC'D BY REGISTRAR <b>FFB 21 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Lee</b>		

WILHELM V. S.

1888

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02270

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D. O. A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hosp.		e. STREET ADDRESS Maple Street	
3. NAME OF DECEASED (Type or print) MILTON KENNEDY BURGNER Jr.		First	Middle
4. SEX Male	5. COLOR OR RACE White	6. MARRIED WIDOWED	7. NEVER MARRIED DIVORCED
8. DATE OF BIRTH 12 Dec. 1906		9. AGE (In years last birthday) 51 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator operator		10b. KIND OF BUSINESS OR INDUSTRY Glenn Dale Sani.	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milton K. Burgner		14. MOTHER'S MAIDEN NAME Minnie M. Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO 173-02-3965	
17. INFORMANT Page H. Burgner (Wife)		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute congestive heart failure (a), stating the underlying cause first. DUE TO (c) Cardiovascular renal disease  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? Cerebral damage due to old cerebral vascular accidents. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m.	Month Day, Year 19	20d. INJURY OCCURRED While at work. <input type="checkbox"/> Not while at work. <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE: <i>John T. Maloney</i>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED February 20, 1958
22a. BURIAL, CREMATION REMOVAL (Specify)	22b. DATE THEREOF Burial Feb 24, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Elmwood Cemetery	22d. LOCATION (City, town, or county) Stephensburg, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Donaldson, Laurel, Md.	ADDRESS	24a. REC'D BY REGISTRAR FEB 25 '58	24b. REGISTRAR'S SIGNATURE Allie Smith

Y. V. SUDARSHAN

1961

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2290

## CERTIFICATE OF DEATH

112271

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>3 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Hills</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>2907 Branch Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Baby Girl</b>	First	Middle	Last	4. DATE OF DEATH <b>Feb 7 1958</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>7 Feb 1958</b>	9. AGE (In years lost birthday) yrs. <b>3</b>	IF UNDER 1 YEAR Months <b>3</b>	IF UNDER 24 HRS Days Hours Min. <b>7</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Clarence Catlett</b>				14. MOTHER'S MAIDEN NAME <b>Irene Indiana Beavers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
				<b>Mother ( Patient )</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO  atelectasis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Pneumonia							
INTERVAL BETWEEN ONSET AND DEATH 3 days 3 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 5501 Hamilton St., Hyattsville, Md.		(County) (State)	
21. I certify that I attended the deceased from <b>Feb 7, 1958</b> to <b>Feb 7, 1958</b> , that I last saw the deceased alive on <b>Feb. 7, 1958</b> , and that death occurred at <b>330 A.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>M.D. 5501 Hamilton St., Hyattsville, Md.</b>							
DATE SIGNED <b>2/10/58</b>							
MEICAL CERTIFICATION							
ACTUAL SIGNATURE <b>John J. Perkins</b>							
PHYSICIAN'S NAME (Type) <b>Dr. John Perkins M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>2/13/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Prince George's General Hospital, Cheverly, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John W. Pern, Jr., Administrator</b>							
ADDRESS <b>20949-99xx</b>				24a. REC'D BY REGISTRAR <b>FEB 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>C.B. couch</b>	

BUREAU V. A.

• FEB 20 1959 •

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 is to be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be filed at your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 2291		Reg. Dist. No. 112272	
1. PLACE OF DEATH a. COUNTY      Prince Georges      MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland      b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 3806 39th Avenue Street	
f. FIRST MIDDLE LAST NAME Henry H. Christian		f. DATE OF DEATH February 21, 1958	
g. SEX Male		h. COLOR OR RACE white	
i. MARRIED Widowed		j. NEVER MARRIED Divorced	
k. DATE OF BIRTH June 10, 1895		l. AGE (In years last birthday) 62 yrs	
m. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		n. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
o. BIRTHPLACE (State or foreign country) Maine		p. IF UNDER 1 YEAR Months Days Hours Min	
q. CITIZEN OF WHAT COUNTRY? U.S.A.			
r. FATHER'S NAME Henry Christian ( Chretien )		s. MOTHER'S MAIDEN NAME Matilda Violette	
t. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		u. SOCIAL SECURITY NO Address	
v. IMMEDIATE CAUSE (a) 976X		w. INFORMANT Eva Christian; same address as # 2.	
x. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), BEING THE UNDERLYING CAUSE LISTED.		y. DUE TO Hemorrhage and shock	
z. DUE TO Gunshot wound of head			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
aa. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		bb. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Self inflicted gunshot wound of head.	
cc. TIME OF INJURY Month, Day, Year Hour 2-21-58 19 11.10 p.m.		dd. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
ee. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		ff. CITY OR TOWN Brentwood, Pr. Geo. Md.	
gg. (County) (State)			
hh. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ii. ACTUAL SIGNATURE John T. Maloney		jj. DATE SIGNED February 21, 1958	
kk. EXAMINER'S NAME (Type) John T. Maloney, M.D.		ll. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
mm. BURIAL CREMATION, DATE THEREOF REMOVAL (Specify) Transportation 2/24/58		nn. NAME OF CEMETERY OR CREMATORIAL Augusta	
oo. LOCATION (City, town, or county) Maine		pp. REC'D BY REGISTRAR DATE FEB 26 '58	
qq. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		rr. REGISTRAR'S SIGNATURE Date	

BURGESS V. B.

FEB 11 1968

REGISTRATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2281 CERTIFICATE OF DEATH

112273

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park		d. STREET ADDRESS 7311 - 15th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7311 - 15th Place				d. STREET ADDRESS 7311 - 15th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MILDA		First Middle		Last CIMERMANIS		4. DATE OF DEATH February	Month Day Year 9, 19 58
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1893		9. AGE (In years last birthday) 64 yrs		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY Latvia	
13. FATHER'S NAME Robert Zebergs				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Richard Cimermanis-7311 15th P. Address Takoma Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, Generalized INTERVAL BETWEEN ONSET AND DEATH 6 months							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Leiomyosarcoma, fundus of stomach ?							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-24-1957, to 2-9-1958, that I last saw the deceased alive on 2-7-1958, and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>S.A. Hillman</u> M.D. 249 Missouri Avenue, N.W. Wash. 11, D.C. Feb. 9, 1958							
PHYSICIAN'S NAME (Type) SAMUEL A. HILLMAN, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 2/15/58				22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORI Rock Creek Cemetery	
22d. LOCATION (City, town, or county) Washington, D.C. (State)				22e. REG'D BY REGISTRAR FEB 13 '58		24b. REGISTRAR'S SIGNATURE <u>A. H. Hines</u>	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company-Washington, D.C.		ADDRESS		24a. REC'D BY REGISTRAR FEB 13 '58			

BURLEAU V. E

1959

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02274

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO MEDICAL EXAMINER: This certificate should be executed by a medical officer, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transfer permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2266		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)	
Prince Georges		MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY Pr. Geo.,	
College Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		14 College Park		d. STREET ADDRESS	
4710 Delaware Street		4710 Delaware Street		e. IS PENDING ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	
Hobart		James	Cline	Month	Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs. Months Days Hours Min
Male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-3-57	2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
*****		*****		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
George G. Cline		Peggy J Howington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown)		16. SOCIAL SECURITY NO		17. INFORMANT	
No		(If yes, give war or dates of service)		Address	
George G. Cline; same address as #2.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					
491X DUE TO Bronchopneumonia					
Conditions, if any, which gave rise to immediate cause (b)					
DUE TO					
cause last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE  EXAMINER'S NAME (Type)		John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED February 8, 1958	
22a. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
Burial		Feb 10, 1958		Fort Lincoln Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR FFF 1 1 '58 DATE	
F. Gasch's Sons		Hyattsville Md.		24b. REGISTRAR'S SIGNATURE Al. Lueck	

BOOKS BY V. S.

THE  
LAW

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12275

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

**2343**

1. PLACE OF DEATH  
a. COUNTY

Prince George's MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Forestville Transient

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

8200 Marlboro Pike S.E.

2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)

a. STATE Maryland

b. COUNTY Prince George

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Suitland

d. STREET ADDRESS

5221 Walnut Lane

e. IS RESIDENT ON A FARM  
YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First Charles Leonard

Middle

Last Collins Jr.

DATE  
OF  
DEATH

Month February

Day 15 Year 58  
19

5. SEX

6 COLOR OR RACE White

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH  
11/19/44

9. AGE (In years  
last birthday)  
13 yrs.

10. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. CITIZEN OF WHAT COUNTRY?

Student

School

District Of Columbia

U.S.A.

13. FATHER'S NAME

Charles Leonard Collins Sr.

14. MOTHER'S MAIDEN NAME

Phyllis Lora Marshall

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

none

Mrs Phyllis Allen, same as # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

812 X

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Hemorrhage and shock

INTERVAL BETWEEN  
ONSET AND DEATH

Fracture of the base of the skull

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMAR~~Y~~  OR CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

Collided with an automobile while sleigh riding

20c. TIME OF INJURY

Month, Day, Year

8:30 XXX  
p.m.

2/15/58

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,  
factory, bus., offce, bldg., etc.)

20f. (City or town)

(County)

(State)

While  
at work  Not while  
at work

Street

Morningside P. G.

Md

21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry  and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

22a. BURIAL, CREMATION, OR  
REMOVAL (Specify)

BURIAL 2/19/58

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

OAKWOOD

ADDRESS

22d. LOCATION (City, town, or county)

(State)

FALLS CHURCH VA.

Md

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

February 16, 1958

23. FUNERAL DIRECTOR'S SIGNATURE

W.W. OHAMBERS CO 517 11TH ST SE.

24a. REC'D BY REGISTRAR

FEB 19 1958

24b. REGISTRAR'S SIGNATURE

Q. Queen

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

EEB

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2292

## CERTIFICATE OF DEATH

Reg. Dist. No.

112273

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>P.G.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>		c. LENGTH OF STAY IN 1b <b>22 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hosp.</b>		d. STREET ADDRESS <b>Md. Blv.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Norvel</b>	Middle <b>Cooksey</b>	4. DATE OF DEATH <b>Feb. 18 1958</b>	Month	Day
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1880</b>	9. AGE (In years, months, days) lost birth day yrs. <b>77</b>	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Charles Cty., Md.</b>	
13. FATHER'S NAME <b>George Cooksey</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-32-6740</b>		17. INFORMANT <b>William E. Cooksey, 4915 V St., S.E.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>				INTERVAL BETWEEN ONSET AND DEATH <b>9 hrs.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO <b>Coronary Thrombosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>9 hrs.</b>	
(c) DUE TO <b>Arteriosclerosis, Generalized</b>				INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Postoperative Cholecystectomy</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/27/58</b> to <b>2/18/58</b> , that I last saw the deceased alive on <b>2/18/58</b> , and that death occurred at <b>1:00 P.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>4500 College Ave., College Park, Md.</b>	
ACTUAL SIGNATURE <b>Wm. A. Halbrook, M.D.</b>				DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Wm. A. Halbrook, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/21/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Washington National</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>N. W. CHAMBERS CO., Riverdale, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>FEB 21 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. L. Gedue</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EDWARD V. S.

113

P. O. V. A. P.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12277

## 2293 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		COUNTRY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park		d. STREET ADDRESS 6923 Carlton Terr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Beatrice	Middle E	Last Coulter	4. DATE OF DEATH Feb	Month 18	Day 19	Year 58
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 15 Sept. 1901	9. AGE (In years last birthday) 53 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bureau of Plant Industry		10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Ralph A Snow			14. MOTHER'S MAIDEN NAME Carrie Price				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital		Address Cheverly, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebro-vascular accident</b> DUE TO <b>hypertensive cardio-vascular disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  <b>Hypertension</b>		(b) DUE TO  <b>hypertension</b>		(c)		10 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 22, 1952</b> , to <b>February 18, 1952</b> , that I last saw the deceased alive on <b>February 17, 1952</b> , and that death occurred at <b>11:50 AM</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Dr. H. Wodak</b> ADDRESS (Street, city or town, state) <b>M.D. 30-C Brandy Ave, Greenbelt, Md</b> DATE SIGNED <b>2-19-1952</b>							
PHYSICIAN'S NAME (Type) <b>Dr. H. Wodak M.D.</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/21/58	22c. NAME OF CEMETERY OR Crematory George Washington		22d. LOCATION (City, town, or county) Hyattsville, Maryland. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Maryland.				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE DATE	

BUREAU V.

FEB 9 4 1958

RECEIVED

1

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 12275

FOR STATE  
ALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PAJ. Page 5 may be retained by your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>4 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. STREET ADDRESS <b>3532 Manor Wood Drive</b>	
f. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>David</b>	Middle <b>Marson</b>	Last <b>Couvillon</b>
4. DATE OF DEATH	Month <b>February</b>	Day <b>10</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-15-1957</b>
9. AGE (In years last birthday) yrs <b>4</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bryson Scally Couvillon</b>		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Bryson Scally Couvillon</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Bailey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Bryson Scally Couvillon; same as #2.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>491X</b> DUE TO <b>Bronchopneumonia</b> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DEATH AND DEATH (d) _____ (e) _____ (f) _____ (g) _____ (h) _____ (i) _____ (j) _____ (k) _____ (l) _____ (m) _____ (n) _____ (o) _____ (p) _____ (q) _____ (r) _____ (s) _____ (t) _____ (u) _____ (v) _____ (w) _____ (x) _____ (y) _____ (z) _____ (aa) _____ (bb) _____ (cc) _____ (dd) _____ (ee) _____ (ff) _____ (gg) _____ (hh) _____ (ii) _____ (jj) _____ (kk) _____ (ll) _____ (mm) _____ (nn) _____ (oo) _____ (pp) _____ (qq) _____ (rr) _____ (ss) _____ (tt) _____ (uu) _____ (vv) _____ (ww) _____ (xx) _____ (yy) _____ (zz) _____ (aa) _____ (bb) _____ (cc) _____ (dd) _____ (ee) _____ (ff) _____ (gg) _____ (hh) _____ (ii) _____ (jj) _____ (kk) _____ (ll) _____ (mm) _____ (nn) _____ (oo) _____ (pp) _____ (qq) _____ (rr) _____ (ss) _____ (tt) _____ (uu) _____ (vv) _____ (ww) _____ (xx) _____ (yy) _____ (zz) _____ (aa) 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GEREAU V.

193

GEREAU V.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2295 CERTIFICATE OF DEATH

112279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>2 hr, 8 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eugene Island Memorial Hospital</b>		d. STREET ADDRESS <b>4403 37th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>ARTHUR</b>	Middle	Last <b>CRAPO</b>	4. DATE OF DEATH	Month <b>February</b>	Day <b>10</b>	Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2/10/58</b>	9. AGE (in years from birthday) yrs. <b>8</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>Benjamin J. Crapo</b>			14. MOTHER'S MAIDEN NAME <b>M. nee M. Hinkston</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>770.5</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (c) DUE TO								
INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Baltimore, Md.</b>		(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>Feb 12</b> , 1958, to <b>Feb 12</b> , 1958, that I last saw the deceased alive on <b>Feb 12</b> , 1958, and that death occurred at <b>11 1/2 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b> DATE SIGNED <b>2-16-58</b>								
ACTUAL SIGNATURE <b>L. M. Mattingly</b>								
PHYSICIAN'S NAME (Type) <b>L. M. Mattingly</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-12-1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>McClintic</b>		22d. LOCATION (City, town, or county) <b>Woods DR</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tobey A. Mattingly</b>		ADDRESS <b>131-1/2 E Wash. St.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>G. P. ...</b>		

CREAU Y.

1928

LIBRARY  
UNIVERSITY OF TORONTO LIBRARIES  
1928

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2296 CERTIFICATE OF DEATH

Reg. Dist. No. 02280

1. PLACE OF DEATH o COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <b>Md</b>		b. COUNTY <b>PG</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Beaver Hghts.</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Gege General Hospital</b>		d. STREET ADDRESS <b>1609 Eastern Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Bernard Curry</b>		First	Middle	Last	4. DATE OF DEATH <b>Feb. 24</b>	Month	Day	Year <b>19 58</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>May 6 1896</b>	9 AGE (In years (last birthday) <b>61 yrs</b>	10 IF UNDER 1 YEAR Months	11 IF UNDER 24 HRS Days	12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elevator operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>					
13. FATHER'S NAME <b>Bernard Curry</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Schwab</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>578 10 1658</b>		17. INFORMANT <b>Friend who cared for pt. Mrs. AB. Gray (same as above)</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491x</b>		DUE TO <i>bilateral carotid branching</i>		INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m.                          19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Greenbelt</b>		(County) <b>Maryland</b>	(State) <b>MD</b>
21. I certify that I attended the deceased from <b>February 20, 1958</b> to <b>February 24, 1958</b> , that I last saw the deceased alive on <b>February 22, 1958</b> , and that death occurred at <b>10:00 AM</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>30-C Ridge Rd, GREENBELT MD</b>		DATE SIGNED <b>2-24-58</b>	
ACTUAL SIGNATURE <i>Hans Wedak</i>									
PHYSICIAN'S NAME (Type) <b>Dr. (Signature) Hans Wedak</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 27, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) <b>Philadelphia, Pennsylvania</b>		(State) <b>PA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>FEB 27 1958</b>		24b. REGISTRAR'S SIGNATURE <b>John W. Smith</b>		DATE	

BUREAU V.

FEB 7 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2269 CERTIFICATE OF DEATH

02281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Prince Georges MARYLAND		Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Hyattsville		Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
Hyattsville Conv. Home	6907 23 <sup>rd</sup> Ave		
3. NAME OF DECEASED (Type or print)	First SAMUEL	Middle L.	Last DAVENPORT
4. DATE OF DEATH	Month FEB	Day 10	Year 1948
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 16, 1858
9. AGE (In years last birthday) 99 yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookbinder		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov	11. BIRTHPLACE (State or foreign country) N.Y.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Address David Davenport 6907 23 <sup>rd</sup> Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTESTINAL OBSTRUCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) INCARCERATED HERNIA DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 DAY years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August, 1947, to FEB 9, 1948, that I last saw the deceased alive on FEB 9, 1948, and that death occurred at 8:30 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE: David A. Lear M.D. ADDRESS (Street, city or town, state) 905 SHERIDAN ST DATE SIGNED 2/10/48			
PHYSICIAN'S NAME (Type) ARNOLD A. LEAR		HYATTSVILLE MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-11-58	
22c. NAME OF CEMETERY OR CREMATORIAL Huddler Cemetery		22d. LOCATION (City, town, or county) Mt Tremper NY	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
David Funeral Home		24a. REC'D BY REGISTRAR FEB 19 '58	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the funeral director.

BUREAU M. S.

TEB o 198

KODAK FILM

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**2297 CERTIFICATE OF DEATH**

62282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>24 hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>	
3. NAME OF DECEASED (Type or print) <b>Baby</b>		d. STREET ADDRESS <b>51 L Ridge Rd.</b>	
First <b>Baby</b>		Middle <b>Em</b>	Last <b>David</b>
4. DATE OF DEATH <b>Feb 23 1958</b>		Month <b>Feb</b>	Day <b>24</b>
		Year <b>1958</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>23 Feb 1958</b>		9. AGE (In years lost birthday) yrs <b>24</b>	10. IF UNDER 1 YEAR Months <b>24</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	10c. IF UNDER 24 HRS Days <b>24</b>
		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>as above</b>
13. FATHER'S NAME <b>Carey</b>		14. MOTHER'S MAIDEN NAME <b>Sue Warren</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT Mother</b>	Address <b>as above</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first <b>Pulmonary atelectasis</b> (b) <b>encephalitis</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 day</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>
21. I certify that I attended the deceased from <b>Feb. 13, 1958</b> to <b>Feb. 24, 1958</b> , that I last saw the deceased alive on <b>Feb. 13, 1958</b> , and that death occurred at <b>7:20 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>3101 ARUNDEL RD.</b>	
ACTUAL SIGNATURE <b>Dr. Irving Grassgreen M.D.</b>		DATE SIGNED <b>MT. RAINIER, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>2/26/58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Prince George's General Hospital</b>
22d. LOCATION (City, town, or county) <b>Cheverly, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Peery, Jr. Administrator</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 3 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Deaneen</b>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 since it will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 3 1960

66764-V-L

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2298 CERTIFICATE OF DEATH

102283

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>		d. STREET ADDRESS <b>4026 - 34th. street</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Minnie B. Donohue</b>		First	Middle	Last	4. DATE OF DEATH <b>2 - 21</b>	Month	Day	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/8/82</b>	9. AGE (In years lost birthday) yrs. <b>75</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b>	12. IF UNDER 24 HRS Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John W. White</b>		14. MOTHER'S MAIDEN NAME <b>Fanny B. Samuels</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-05-5656B-</b>		17. INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>449</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteria - Pneumonia</b>						INTERVAL BETWEEN ONSET AND DEATH		
(b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Cardio - renal disease</b>								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>4</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>3717-38th Ave</b>		20f. (City or town) (County) (State) <b>Baltimore City Md</b>		
21. I certify that I attended the deceased from <b>2/18</b> , 19 <b>58</b> to <b>2/21</b> , 19 <b>58</b> that I last saw the deceased alive on <b>2/21</b> , 19 <b>58</b> , and that death occurred at <b>8:30</b> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>3717-38th Ave</b>		DATE SIGNED <b>2/21/58</b>
ACTUAL SIGNATURE <b>George J. Hagege</b>								
PHYSICIAN'S NAME (Type) <b>George J. Hagege</b>		22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) <b>Cooper Memorial Md</b>				(State) <b>Md</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/24/58</b>		22c. NAME OF CEMETERY OR CREMATORIALy <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) <b>Cooper Memorial Md</b>		(State) <b>Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Natalie's Funeral Home</b>		ADDRESS <b>Mt. Rainier, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 24 1958</b>		24b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 showing the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRUNCAU V.

123



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2270 CERTIFICATE OF DEATH

Reg. Dist. No.

102284

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>73 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5604--39th Avenue</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
3. NAME OF DECEASED (Type or print) <b>MINNIE</b>		First <b>LOUISE</b>	Middle <b>DORSEY</b>
4. DATE OF DEATH <b>February 27th, 1958</b>		Month <b>February</b>	Day <b>27</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>April 24, 1884</b>		9. AGE (In years last birthday) <b>73 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>
11. BIRTHPLACE (State or Foreign country) <b>Howard County, Md.</b>		12. IF UNDER 24 HRS. Days <b>0</b>	13. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	
13. FATHER'S NAME <b>Godfrey Rice</b>		14. MOTHER'S MAIDEN NAME <b>Kolpack; Augusta</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Mary Johaneck, 5604--39th Ave, Hyattsville</b>		Address <b>111 Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Coronary Atherosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 16</b> , 1958, to <b>Feb 27</b> , 1958, that I last saw the deceased alive on <b>Feb 21</b> , 1958, and that death occurred at <b>11:00 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Leon R. Levitsky</b> PHYSICIAN'S NAME (Type) <b>Leon R. Levitsky</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/3/1958</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>St. John's Church Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pfeiffers Corner, Howard Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MR 4 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Chase</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Y. V. DURRANT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12285

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2341		2. USUAL RESIDENCE (Where deceased lived. If institutional, give address before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Prince George MARYLAND		c. STATE Maryland		
Camp Springs		4 mo		b. COUNTY Prince George		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		5428 Center Drive		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
e. LENGTH OF STAY IN 1b		d. STREET ADDRESS		Camp Springs		
5428 Center Drive		5428 Center Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year	
Wallace Llewellyn Faust				FEBRUARY 4	1958	
5. SEX		6. COLOR OR RACE	7. MARRIED	8. DATE OF BIRTH	9. AGE (In years, months, days)	
Male White		WIDOWED	NEVER MARRIED	Jul, 5, 1922	35 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Director		Blood Bank Delaware		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		
Wallace Llewellyn Faust		Jeanette Wadsworth		U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		
Yes		414-18-0728		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Exhaustion				
151X		DUE TO				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)				
		DUE TO				
		(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION LISTED IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
19						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						DATE SIGNED
ACTUAL SIGNATURE <i>James I. Boyd</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINEE'S NAME (Type) James I. Boyd		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL CREMATION REMOVED <input type="checkbox"/>		22b. DATE THEREOF Feb. 7, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Arlington Natl Cem.		22d. LOCATION (City, town, or county) Arlington VA (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Lee, Son</i>		ADDRESS West. D.C.		24a. REC'D. BY REGISTRAR Feb. 6 '58		24b. REGISTRAR'S SIGNATURE <i>O. J. Edwards</i>

BUKLAU V. 8

CB 6 1959

BUKLAU V. 8

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

V5 A15 (4)  
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2299

## CERTIFICATE OF DEATH

12286

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <b>Cheverly, 5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>		d. STREET ADDRESS <b>4908 Blackford Road</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Ettle</b>		First	Middle	Last	4. DATE OF DEATH <b>Fletcher</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-25-07</b>	9. AGE (In years lost birthday) <b>50 yrs</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Chad T. Jones</b>			14. MOTHER'S MAIDEN NAME <b>Pauline Helton</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <b>No</b>		16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>Karl W. Fletcher</b>		Address <b>College Park, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>581.c</b> DUE TO <b>Hepatic coma</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterial Cirrhosis</b> 2 years (c) <b>Intermittent cholangitis</b> 4 years.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>May 21, 1953</b> , to <b>February 7, 1958</b> , that I last saw the deceased alive on <b>February 6, 1958</b> , and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above.					ADDRESS (Street, city or town, state) <b>30-C Brady Rd, Greenbelt, Md.</b>			DATE SIGNED <b>2-7-1958</b>
ACTUAL SIGNATURE <b>Hans Wodak</b>								
PHYSICIAN'S NAME (Type) <b>Dr. Hans Wodak</b>								
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Transportation</b>		22b. DATE THEREOF <b>2/10/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Akron</b>		22d. LOCATION (City, town, or county) (State) <b>Ohio</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>De F. F. Deuch</b>		

W. V. DAUBER

100-113

REVIEW

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

112287

2345

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH

a. COUNTY

PRINCE GEORGES MARYLAND

## b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

CLINTON

## c. LENGTH OF STAY IN 1b

RURAL and give nearest town

12 yrs.

## d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

RT 2 Box 270-A

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

d. STATE

MD.

b. COUNTY

PRINCE GEORGES

## c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

CLINTON

## d. STREET ADDRESS

RT 2 Box 270-A

## e. IS RESIDENCE ON A FARM?

YES  NO 3. NAME OF DECEASED  
(Type or print)

First MIDDLE

Lost

4. DATE OF DEATH

FEB. 16 1958

## 5. SEX

F

## 6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

APR. 5-1876

## 9. AGE (In years lost birthday)

81 yrs

## 10. IF UNDER 1 YEAR

Months Days Hours Min

## 11. IF UNDER 24 HRS.

Months Days Hours Min

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

## 10b. KIND OF BUSINESS OR INDUSTRY

NONE

## 11. BIRTHPLACE (State or foreign country)

CHIPLEY, GA.

## 12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME

ALEXANDER McDONALD

## 14. MOTHER'S MAIDEN NAME

B. A. CHAMBERS

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

(If yes, give war or dates of service)

NO

## 16. SOCIAL SECURITY NO.

NONE

## 17. INFORMANT

INEZ HOUSER

## Address

CLINTON RT 2 Box 270-A

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

46 days

CONGESTIVE HEART FAILURE

INTERVAL BETWEEN  
ONSET AND DEATH  
3 days

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause first.ARTERIOSCLEROTIC CARDIOVASCULAR  
DISEASE

10+ years

(b)

DUE TO

ARTERIOSCLEROTIC CARDIOVASCULAR  
DISEASE

10+ years

(c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

## 20a. ACCIDENT WAS UNDERLYING

## OR CONTRIBUTING CAUSE OF DEATH

(If either, none, medical, or other)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 20)

None

## 20c. TIME OF INJURY Month, Day, Year

White Not white

at work  at work at work 

## 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

## 21. I certify that I attended the deceased from SEPT 1958 to FEB. 1958, that I last saw the deceased alive on JUN 31 1958, and that death occurred at 2 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

## ACTUAL SIGNATURE

ARTHUR SHAUER JR.

CLINTON MD.

FEB. 16, 1958

EURO V. S

1000

1000

102288

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2271 CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>PRINCE GEORGES</i>		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <i>Wash. D.C.</i> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HYATTSVILLE, MD.</i>	c. LENGTH OF STAY IN lb <i>5 MONTHS.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C.</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PAINT BRANCH NURSING HOME</i>	e. STREET ADDRESS <i>3120-Powder Mill Road</i>	d. STREET ADDRESS <i>22 EYE ST, N.W.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>ROBERTA</i>	First <i>ANN</i>	Middle <i>GRADY</i>	Last Month Day Year <i>JUL. 28 1958</i>				
4. SEX <i>FEMALE</i>	5. COLOR OR RACE <i>WHITE</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>JANUARY 27, 1881</i>				
8. AGE (In years lost birthday) <i>77 yr.</i>	9. IF UNDER 1 YEAR Months Days Hours Min	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	11. BIRTHPLACE (State or foreign country) <i>Northumberland, Virginia U.S.A.</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
13. FATHER'S NAME <i>LUCIOUS CLAYTON</i>	14. MOTHER'S MAIDEN NAME <i>Roberta ANN Edmonds.</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mrs Pearl C. Heddings</i>	Address <i>5611 Randolph St., Villa Hgts, Md</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 mos.</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Arteriosclerosis</i>				5 years			
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
19							
21. I certify that I attended the deceased from <i>June 2, 1956</i> , to <i>Feb 28, 1958</i> that I last saw the deceased alive on <i>Feb 28, 1958</i> , and that death occurred at <i>11 M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Norman Donist Jomeau</i>	ADDRESS (Street, city or town, state) <i>3503 Penny St</i>				DATE SIGNED <i>2/28/58</i>		
PHYSICIAN'S NAME (Type) <i>Norman Donist Jomeau</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>March 4, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) <i>Southland, Maryland</i>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. CHAMBERS, 517 11th St., N.W.</i>		ADDRESS	24a. REC'D BY REGISTRAR <i>DATE MAR 4 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Chambers</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shall be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURLAU V. S.

1253

1253

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 112289

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PHM3. Page 5 may be retained by your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2346		2. USUAL RESIDENCE (Where deceased lived - If institution, residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Length of Stay in lb		a. STATE Maryland b. COUNTY Anne Arundel	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				14 STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First Middle		15. DATE OF DEATH Month Day Year	
4. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH	
Female		Black		Nov. 19, 1957	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
None				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Robert Williams		Estelle Griffith		U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Estelle Griffith	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO			
716.0		Shock			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OF CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Nov. 24, 1958				20f. (City or town) (County) (State)	
12 p.m.				Annapolis (Anne Arundel) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
Burial		2-24-1958		Chesapeake	
22d. LOCATION (City, town, or county) (State)					
Owensville, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
William Reed #108 Wash St. Annapolis				24b. REGISTRAR'S SIGNATURE	
207720				DATE: FEB 27 '58	

GOULD V. E.

1958

ED SAWYER

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02290

FOR STATE  
HEALTH DEPT.



1

Please  
execute this certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AT 5PM  
5M 2/57

1. PLACE OF DEATH a. COUNTY		2300 Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY Pr. Geo.					
Cheverly		D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		College Park		d. STREET ADDRESS					
Prince Georges General Hospital		9078 Baltimore Boulevard		9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH		Month	Doy	Year	
Frederick		Charles	Hader	Lost	February	7	19	50	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years, full birthday)			
Male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-28-06		52	Yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
Salesman		Shoe		New York				U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Charles F. Hader		Charlotte A. Goddard							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		Address 267 Onington Ave. Minerva Buecemia (Sister) Brooklyn, N.Y.			
Yes WW II		?		Minerva Buecemia (Sister)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1									
DUE TO Coronary thrombosis									
Conditions, if any, which gave rise to immediate cause (b) Coronary atherosclerosis									
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
19									
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
<b>John T. Maloney, M.D.</b>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE									
NAME (Type)									
22a. BURIAL, CREMATION, (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)	
Burial		2/14/58		Ocean View Cemetery		Staton Island		N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE						24a. REC'D. BY REGISTRAR <b>FEB 13 1958</b> 24b. REGISTRAR'S SIGNATURE <b>West Beach</b>			
F. Gasch's Sons Hyattsville, Md.						DATE			

BUREAU V. S.

FEB 10 1953

REGISTRATION  
BUREAU V. S.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

**CERT:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 which is detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9-11-12-13-4-5 et  
2272

## CERTIFICATE OF DEATH

112291

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Hyattsville		1 yr		Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5801 42nd Avenue		17214 23rd Ave		g. DATE OF DEATH Month Day Year 2 - 24 - 1958	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	
MARTHA				HALE	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday 87 yrs.) IF UNDER 1 YEAR Months Days Hours Min.
F		W		SEPT. 29, 1870	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				New Jersey U.S.	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Lemuel Miller		Martha Gregory			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes, give war or dates of service)				Eugene Hale	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH Ma.	
420.0		DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)			
{		DUE TO			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1957, to Feb. 23, 1958, that I last saw the deceased alive on Feb. 23, 1958, and that death occurred at 8:30 A.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 905 Sheridan St. Hyattsville, Maryland	
ACTUAL SIGNATURE		M.D.		DATE SIGNED 2/24/58	
PHYSICIAN'S NAME (Type)		ARNOLD A. LEAR			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
Burial		Feb 27, 1958		CONGRESSIONAL CEMETERY	
22d. LOCATION (City, town, or county) (State)					
Washington D.C.					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 27 '58	
LEL FUNERAL HOME 300 4TH ST NE				24b. REGISTRAR'S SIGNATURE	

BUREAU Y.

FEB 27 1959

KL5EYED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2273 CERTIFICATE OF DEATH

02292

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Hyattsville Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bell's Nursing Home		d. STREET ADDRESS 1308 Nicholson St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Stephen Scott Hale	Middle	4. DATE OF DEATH Month Feb 15, 1958 Day Year 1958 15 19
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 12, 1958
9. AGE (In years lost birthday) yrs. 1		10. IF UNDER 1 YEAR Months 1 Days Hours Min.	11. IF UNDER 24 HRS Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Washington D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Ryland Alton Hale		14. MOTHER'S MAIDEN NAME Margaret Chamberland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT none Ryland Alton Hale Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Cerebral hemorrhage & convulsive status Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Hydrocephalus (c)		INTERVAL BETWEEN ONSET AND DEATH Death on	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/10</u> , 19 <u>58</u> , to <u>2/15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/15</u> , 19 <u>58</u> , and that death occurred at <u>2:00 a.m.</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Thomas A. Christensen, M.D.</u>		ADDRESS (Street, city or town, state) <u>6905 Belts Blvd</u> DATE SIGNED <u>2/15/58</u>	
PHYSICIAN'S NAME (Type) Thomas A Christensen			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/15/58	
22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE FEB 15 58	
ADDRESS Hyattsville, Md.		24b. REGISTRAR'S SIGNATURE <u>Connerich</u>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Loge  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, and completely filled in, it may be retained by the funeral director. page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CELESTE V.

3 1959



1  
TO STATE  
HEALTH DEPT.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02293

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a Burial-Transit Permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) b. STATE Maryland	
2267		c. LENGTH OF STAY IN lb Transient	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Saint Andrews Church		d. STREET ADDRESS 18-- Cheverly Circle	
e. IS RE DINING ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Phyllis		First Middle Georgia	Hawkins
4. DATE OF DEATH February 28 1958		Month Year	Doy Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARR ED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 11, 1902		9. AGE (in years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Organist		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Hawkins		14. MOTHER'S MAIDEN NAME Daisy Petrie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 217-36-6520	
17. INFORMANT Frank Hawkins; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 22. X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b)		Cerebral compression	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)		Cerebral vascular accident	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)		Hypertension	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> February 28, 1958	
EXAMINER'S NAME (Type) John T. Maloney, M.D.			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/58	
22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Arlington Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR MAR 3 1958	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>W. J. Reich</i>	

BUREAU V.

MAR 6 1968

135615

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/trans. permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2274

112291

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Avondale-Hyattsville</b>	c. LENGTH OF STAY IN lb <b>6 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Avondale-Hyattsville</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4909 La Salle Road</b>	d. STREET ADDRESS <b>4909 La Salle Road</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Catherine Burns Hayes</b>	First	Middle	Last	4. DATE OF DEATH <b>February 19, 1958</b>	Month	Day	Year
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-18-00</b>	9. AGE (In years last birthday) <b>57</b> yrs	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13. FATHER'S NAME <b>Harry Burns</b>	14. MOTHER'S MAIDEN NAME <b>Brigid Fegan</b>	Address
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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490X	DUE TO <b>Toxemia</b>	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), <u>stating the underlying cause first.</u>	(b) DUE TO <b>Lobar pneumonia, myocarditis and hepatitis</b>	
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) <b>Arlington</b> (State) <b>Virginia</b>
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21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
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ACTUAL SIGNATURE <i>John T. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <b>February 19, 1958</b>
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EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
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22a. BURIAL, CREMATION, REMOVAL (Society) <b>Burial</b>	22b. DATE THEREOF <b>2/24/1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National Cem.</b>	22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>Nally's Funeral Home Inc.</b>	ADDRESS <b>Mt. Rainier, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>FEB 24 '58</b>	24b. REGISTRAR'S SIGNATURE <b>John T. Maloney</b>
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BUREAU Y.

FEB 24 1959

RECEIVED

02295

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Suitland		c. LENGTH OF STAY IN lb 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  X Suitland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3202 Ryan Drive			d. STREET ADDRESS 3202 Ryan Drive		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Sadie	Middle Irene	Last Hays	4. DATE OF DEATH February 28 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Oct. 9, 1879	9. AGE (In years from last birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) District of Columbia U. S. A.	
13. FATHER'S NAME George Robey			14. MOTHER'S MAIDEN NAME Sarah Moulden		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none 17. INFORMANT Mrs Irene Millsap, same as # 2 Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X DUE TO Cerebral thrombosis Conditions, if any, which gave rise to immediate cause (b) DUE TO Cardiovascular renal disease (a), stating the underlying cause last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE  James I. Boyd			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) James I. Boyd			DATE SIGNED 2/28/58		
22a. BURIAL CREMATION (Specify) Burial		22b. DATE THEREOF 3-4-58		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	
22d. LOCATION (City, town, or county) Suitland, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co Inc.			ADDRESS 517 11th St. E.		
			24a. REC'D BY REGISTRAR MAR 4 '58		
			24b. REGISTRAR'S SIGNATURE Av. J. ...		

BUREAU V. S.

MAR 4 1953

SEARCHED INDEXED  
SERIALIZED FILED

**INSTRUCTIONS**

**TO ATTEND PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10W

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18****CERTIFICATE OF DEATH**

02296

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Wash., D.C. (If rural give location)
TOWN Gatesville	2 yrs	STREET ADDRESS	1120 8th St. S.E.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Gatesville Nursing Home			
<b>3. NAME OF DECEASED (Type or Print)</b>		<b>4. DATE OF DEATH</b>	
(First) Male White	(Middle) Patrick	(Last) Healy	Feb. 11 1958
SEX Male	CO. OR RACE White	SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify) Wedowed	DATE OF BIRTH 8-23-1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	AGE last birthday 84	IF UNDER 1 YEAR Months Years
13. FATHER'S NAME Thomas Healy	11. BIRTHPLACE (State or foreign country) Wash. DC		IF UNDER 24 HRS Days Hours Min.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
17. INFORMANT & ADDRESS Frank J. Healy, his side bro		18. MEDICAL CERTIFICATION Bronchopneumonia	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  IMMEDIATE CAUSE (A) _____ ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 5-6 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized arteriослероз.		—	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County)	
M. at work		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 5, 1957</u> , to <u>Feb. 11, 1958</u> , that I last saw the deceased alive on <u>2/10/58</u> and that death occurred at <u>4:59 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>William C. Fairhurst</u>		ADDRESS (Street, city, town, state) M.D. 2932 W. 36th St. E.	
DATE SIGNED <u>2/10/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIES) Burial	DATE THEREOF 2-13-1958	NAME OF CEMETERY OR CREMATORIAL Mt. Olivet	LOCATION (City, town, or county) Wash., D.C. (State)
24. REC'D BY REGISTRAR FEB 13 '58	REGISTRAR'S SIGNATURE <u>John C. Fairhurst</u>	25. FUNERAL DIRECTOR'S SIGNATURE FEB 13 '58	
DATE FEB 13 '58		ADDRESS <u>W. 36th St. E.</u>	

BULAWY V. S.

1953  
BULAWY

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of the death.

112297

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**CERTIFICATE OF DEATH**

Item 7 11-15-58 pg 2301 Item 7 11-15-58 pg 2301 Item 7 11-15-58 pg 2301 Item 7 11-15-58 pg 2301

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		d. STREET ADDRESS 3505 37th St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anna		First Mure	Middle Hohman	Last	4. DATE OF DEATH Feb 26 Feb 1958	Month 19	Year 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 - 25 - 1888	9. AGE (In years last birthday) 72 69 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) County Clark, Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Patrick Torkey		14. MOTHER'S MAIDEN NAME Anne Cashman Doyle					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mary V. Hohman, address above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		19. INTERVAL BETWEEN ONSET AND DEATH 5 days					
20. MEDICAL CERTIFICATION		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Montgomery County, Maryland		(County) (State)	
21. I certify that I attended the deceased from June 1957 to Feb 26, 1958, that I last saw the deceased alive on Feb 26, 1958, and that death occurred at 7:20A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 3505 Perry St., Louisville, Ky.		DATE SIGNED 2/27/58	
ACTUAL SIGNATURE Dr. Norman Comeau M.D.							
PHYSICIAN'S NAME (Type) Nalley Funeral Home, Mt. Rainier Md.		22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 2/27/58		22c. NAME OF CEMETERY OR CREMATORIAL Calvary	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley Funeral Home, Mt. Rainier Inc., Md.		ADDRESS		24a. REC'D BY REGISTRAR MAR 1 '58		24b. REGISTRAR'S SIGNATURE Albert J. Nalley	

BURLAU V. S.

3 - 193

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

112298

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its duly granted agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		23										Reg. Dist. No.	
1. PLACE OF DEATH		a. COUNTY			Prince Georges			MARYLAND			2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb			Cheverly			D.O.A.			d. STATE Maryland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					Prince Georges General Hospital						e. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)		
e. IS REVENGE ON A FARM?											E. Riverdale		
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First			Middle			Last			4. DATE OF DEATH		
Harold		Joseph			Hughes			Hughes			February 4th		
5. SEX		6. COLOR OR RACE		7. MARRIED		NEVER MARRIED <input checked="" type="checkbox"/>		B. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		white		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		May 10, 1903		54 yrs		IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)								12. CITIZEN OF WHAT COUNTRY?	
Vice President		Visual Slide Co.		New York State								U.S.A.	
13. FATHER'S NAME		William Joseph Hughes		14. MOTHER'S MAIDEN NAME		Mary Crosby		Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Rita Hughes; same address as #2.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute congestive heart failure											
+ 44 X DUE TO													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Cardiovascular renal disease											
DUE TO													
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
19													
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												DATE SIGNED	
ACTUAL SIGNATURE <i>John T. Maloney</i>		EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		February 4, 1958	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/1958		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Washington, D.C. (State)							
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		ADDRESS		24a. REC'D BY REGISTRAR FEB 10 '58		24b. REGISTRAR'S SIGNATURE <i>John T. Maloney</i>							
VS. A15ME 5M 2/57													

BUREAU V. S

FEB 1 1958

BUREAU V. S

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2393 CERTIFICATE OF DEATH

(12299)

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		d. STREET ADDRESS 3511 Emerson St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Elise	Middle	Lost	4. DATE OF DEATH Hurst	Month Feb Day 18 Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 16, 1875	9. AGE (In years last birthday) 82 <del>10</del> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Hume, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Richard Kirby		14. MOTHER'S MAIDEN NAME Mary Jane Kirby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) 42000		16. SOCIAL SECURITY NO. None	17. INFORMANT Hospital Records	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO coronary occlusion		After a clear heart attack		INTERVAL BETWEEN ONSET AND DEATH year 6 hours	
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Oakton	(County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 9:00 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 4314 Colle L St. Hyattsville	
ACTUAL SIGNATURE	Dr. Teel Bergeman				DATE SIGNED
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb/22, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Flint Hill	22d. LOCATION (City, town, or county) (State) Oakton, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John W. Bergeman		ADDRESS Vienna Va	24a. REC'D BY REGISTRAR FEB 23 '58		24b. REGISTRAR'S SIGNATURE John W. Bergeman
			DATE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1951-11-10  
V. A.

858

1951-11-10  
V. A.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2304

## CERTIFICATE OF DEATH

Reg. Dist. No.

02300

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>13 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		d. STREET ADDRESS <b>4715 Queensbury Road</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4715 Queensbury Road</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>GEORGE</b>		First <b>WILSON</b>	Middle <b>HUTH</b>	Lost <b>HUTH</b>	4. DATE OF DEATH <b>February 12th, 1958</b>	Month <b>Feb</b>	Day <b>12</b>	Year <b>1958</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Nov. 23rd, 1873</b>	9. AGE (In years last birthday) <b>84 yrs</b>	IF UNDER 1 YEAR Months <b>84</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>		11. BIRTHPLACE (State or foreign country) <b>Milton, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Nathaniel Huth</b>		14. MOTHER'S MAIDEN NAME <b>Martha Jones</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Elizabeth A. Huth, 4715 Queensbury Rd.,</b>		Address <b>Riverdale, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> DUE TO <b>40.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last <b>artero-sclerotic heart</b>						INTERVAL BETWEEN ONSET AND DEATH <b>week</b>				
(b) DUE TO <b>Chronic disease</b>										
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Hyattsville, Md.</b>		(County) <b>Hyattsville, Md.</b>		(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>Jan 13, 1958</b> to <b>Feb 12, 1958</b> that I last saw the deceased alive on <b>2-6-58</b> , 19 <b>58</b> , and that death occurred at <b>12:20 P.M.</b> from the causes and on the date stated above ACTUAL SIGNATURE <b>John P. Clum</b>						ADDRESS (Street, city or town, state) <b>6110--43rd Ave.,</b>		DATE SIGNED <b>2/12/1958</b>		
PHYSICIAN'S NAME (Type) <b>John P. Clum</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 15/1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>George Washington Cem.</b>		22d. LOCATION (City, town, or county) <b>Riggs Rd. Extd. Hyattsville,</b>		Pr. Geo. Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>FEB 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W.W. Chambers</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURGESS V. E.

ED 24 199



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03660

2275

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Prince George MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hyattsville

c. LENGTH OF STAY IN lb  
RURAL and give nearest town

2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)

d. STATE

Md.

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

x Chillum Terrace

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

d. STREET ADDRESS

1832 Cox Avenue

e. IS RESIDENCE  
ON A FARM?YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First JOSEPH

Middle INOFF

Last

4. DATE  
OF  
DEATH

Month Feb

Day 11

Year 1958

5. SEX

m.

6. COLOR OR RACE

WHITE

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

8. DATE OF BIRTH

8-18-1890

9. AGE (In years  
lost birthday)

69 yrs

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

Semi Retired Junk Dealer

Russia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Kapoleon

14. MOTHER'S MAIDEN NAME

Olga

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

577-48-5131

17. INFORMANT

Samuel Doff 820 Fairmount Avenue

Address

Chillum

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)INTERVAL BETWEEN  
ONSET AND DEATHConditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause lost.Metastatic Carcinoma - Generalized  
Primary Carcinoma of Lt. Kidney 5 months  
Generalized Atherosclerosis 3 years

MEDICAL CERTIFICATION

19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPSY  
PERFORMED?  
YES  NO 20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. 19  
p. m.20d. INJURY OCCURRED  
While at work  Not while at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from December 1957 to February 1958, that I last saw the deceased alive on Feb 11, 1958, and that death occurred at 11 A.M. from the causes and on the date stated above.

ACTUAL  
SIGNATUREPHYSICIAN'S  
NAME (Type)

ADDRESS (Street, city or town, state)

DATE SIGNED

22a. BURIAL, CREMATION, DATE THEREOF  
REMOVAL (Specify)

Burial 2/12-1958 Flat Memorial Park

22d. LOCATION (City, town or county)

Falls Church Va (State)

23. FUNERAL DIRECTOR'S SIGNATURE

Goldberg Funeral Home Washington

ADDRESS

24a. REC'D BY REGISTRAR

DATE MAR 10 '58

24b. REGISTRAR'S SIGNATURE

(Signature)

GUINAY V. A.

AR 10 1963

CLERK'S  
CLERK'S

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02301

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		Reg. Dist. No. _____												
M		1. PLACE OF DEATH a. COUNTY      Prince Georges      MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      Cheverly      c. LENGTH OF STAY IN 1b D.O.A.					2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE      Maryland      b. COUNTY      Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      X Deanwood Park							
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS 5109 Nye Street							
2		3. NAME OF DECEASED (Type or print)		First Evelyn	Middle Jackson	Last	4. DATE OF DEATH	Month February	Day 9th	Year 19 58				
		5. SEX Female		6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 17, 1903	9. AGE (In years last birthday) 54 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min					
3		10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
		13. FATHER'S NAME H. R. Jackson		14. MOTHER'S MAIDEN NAME Anna Thomas		Address George Jackson; 5216 Maple Road, Deanwood Park								
4		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-36-2546		17. INFORMANT George Jackson		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33 IX DUE TO Cerebral compression  Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO Cerebral vascular accident  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						
		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH										
5		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED February 9, 1958							
6		22a. BURIAL, CREMATION, OR REMOVAL (Specify) 2-75-58		22b. DATE THEREOF 2-75-58		22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn		22d. LOCATION (City, town, or county) Washington D.C.						
		23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington, Jr. 467 N St NW Wash DC		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 13 '58		24b. REGISTRAR'S SIGNATURE A. Lee						

FBI  
BUREAU V. S.

3-10-1958

11-22-58

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2396 CERTIFICATE OF DEATH

Reg. Dist. No.

02392

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Krince Georges</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Pr. Georges.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. LENGTH OF STAY IN b. <i>3/3 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park.</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Leland Memorial Hosp.</i>		d. STREET ADDRESS <i>8619 Rhode Island Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Callie B. Jenkins</i>		First	Middle	Lost	4. DATE OF DEATH <i>Feb. 1, 1958.</i>	Month	Day	Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-22-1903</i>		9. AGE (In years lost birthday) <i>54 yrs.</i>	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sheet Metal Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>self employed</i>		11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>George Jenkins</i>		14. MOTHER'S MAIDEN NAME <i>Mary?</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Wife</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
INTERVAL BETWEEN ONSET AND DEATH <i>Several hours</i>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		Month Doy Year	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>4404 Queensbury Rd. Riverdale, Md.</i>	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on <i>2-1-58</i> , 19 <i>58</i> , and that death occurred at <i>1:33 PM</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Donald R. Purdie</i> M.D. <i>4404 Queensbury Rd. Riverdale, Md.</i> PHYSICIAN'S NAME (Type) <i>Donald R. Purdie</i> 4404 Queensbury Rd. Riverdale, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/4/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) <i>Colmar Manor, Md.</i> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons Hyattsville, Maryland.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>FEB 3 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Doris Miller</i>		

BUREAU V. S.

3 - 13

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

23-7

## CERTIFICATE OF DEATH

Reg. Dist. No.

02303

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>10 hr</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accokeek</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>Rt. 1 Box 877</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Gregory</b>	Middle <b></b>	Last <b>Johnson</b>	4. DATE OF DEATH	Month <b>Feb</b>	Day <b>22</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 June 1957</b>		9. AGE (In years last birthday) yrs. <b>8</b>	10. IF UNDER 1 YEAR Months <b>8</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Walter Robert Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Green</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Walter R. Johnson Rt. 1, Box 877, Accokeek, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>492 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Washington, D.C.</b>	(County) <b>D.C.</b>	(State) <b>D.C.</b>
21. I certify that I attended the deceased from <b>2/21</b> , 19 <b>58</b> , to <b>2/22</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/21</b> , 19 <b>58</b> , and that death occurred at <b>4:15A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Albert J. Modlin M.D. 388 Madtree Ave, Laurel, Md.</b>							
ACTUAL SIGNATURE <i>Albert J. Modlin M.D.</i>		DATE SIGNED <b>2/26/58</b>					
PHYSICIAN'S NAME (Type) <b>Dr. Albert Modlin M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/26/1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Washington, D.C.</b>		(State) <b>D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Rhine V.P.</i>		ADDRESS <b>901 3d St. S.W.</b>		24a. REC'D BY REGISTRAR <b>FEB 26 '58</b>	24b. REGISTRAR'S SIGNATURE <b>John T. Rhine</b>		

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PMS. Page 5 may be retained by your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		23-68		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)	
Prince Georges County		Maryland		b. STATE Maryland Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		CITY LENGTH OF STAY IN 16 Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Capital Heights		Baltimore		X Capital Heights	
4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Prince George's General Hospital 6001 Call Street					
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year
Sarah				February	15 1958
5. SEX		6. COLOR OR RACE	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years from birthday) 67 yrs.
Female		White		January 17, 1891	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Own Home		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
Israel Rosenfeld		Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
(If yes, give war or dates of service)				Myer Kans Capital Heights Maryland.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
442 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO	
(b)		Acute congestive heart failure	
(c)		Cardiovascular renal disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town)	(County)	(State)
Hour o. m. p. m.	19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
--	--	--	--	--	--	--

ACTUAL SIGNATURE	JAMES I. BOYD	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type)	JAMES I. BOYD	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVE (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	22d. LOCATION (City, town, or county)
Burial	2-8-58	Cedar Hill Cemetery	Suitland, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE	B. Danzansky & Sons	3501 14th St., N.W.	24a. REC'D BY REGISTRAR FEB 19 '58	24b. REGISTRAR'S SIGNATURE Albert Edelstein
			DATE	

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FEB 11 1968

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2349

## CERTIFICATE OF DEATH

Reg. Dist. No. 112305

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Melroseville</i>		c. LENGTH OF STAY IN 16 <i>2 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>19012 Horatio St</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	
f. STREET ADDRESS <i>7108 Eversfield Drive</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARGARET</i>		First <i>FOX</i>	Middle <i>KELLER</i>
4. DATE OF DEATH <i>FEB</i>	Month <i>3</i>	Day <i>1958</i>	Year
S SEX <i>F</i>	6. COLOR OR RACE <i>Ca</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 14, 1893</i>
9. AGE (In years from birthday) <i>64 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife (rttd)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>Address Hyattsville, Md.</i>	
13. FATHER'S NAME <i>— FOX</i>		14. MOTHER'S MAIDEN NAME <i>—</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NO</i>	
17. INFORMANT <i>Mr. Howard L. Keller - 7108 Eversfield Dr.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral Pulmonary Embolism</i>	
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first</i>		INTERVAL BETWEEN ONSET AND DEATH <i>—</i>	
(b) DUE TO <i>Cerebral Thrombosis</i>			
(c) <i>Hypertension Arterio sclerosis</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 3, 1958</i> to <i>Feb 14, 1958</i> , that I last saw the deceased alive on <i>FEB 3, 1958</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>4713-Berwyn Rd</i> DATE SIGNED <i>2/3/58</i>			
ACTUAL SIGNATURE <i>W.L. Etienne</i>		PHYSICIAN'S NAME (Type) <i>W.L. ETIENNE</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/16/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Druide Ridge Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Pikesville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Wickens &amp; Sons - Balt. 17 Feb 1958</i>		ADDRESS <i>110 W. Saratoga St</i>	
24a. REC'D BY REGISTRAR <i>Feb 17 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Albertine</i>	

RECEIVED  
FEB 6 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

Reg. Dist. No. 12306

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE [Where deceased lived if institution, Residence before admission] a. STATE <i>Pennsylvania</i> b. COUNTY <i>Philadelphia</i>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <i>Charlottesville</i>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <i>Philadelphia</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince George's General Hospital</i>		d. STREET ADDRESS <i>McCalman and Harvey St.</i>	
e. NAME OF DECEASED <i>Sadie</i> First Middle Lost		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
f. SEX <i>Female</i> COLOR OR RACE <i>White</i>		g. DATE OF BIRTH <i>April 5, 1900</i>	
h. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		i. AGE (In years last birthday) <i>57 yrs</i>	
j. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		k. 10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home New York</i>	
l. 11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		m. 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
n. 13. FATHER'S NAME <i>Edward Shaw</i>		o. 14. MOTHER'S MAIDEN NAME <i>Mary</i>	
p. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		q. 16. SOCIAL SECURITY NO.	
r. 17. INFORMANT <i>Walter Kemp</i>		s. ADDRESS <i>Same as #2</i>	
t. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Condensed Incorporated</i> DUE TO <i>816X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Refracture of heart</i> DUE TO <i>multiple fracture</i> (c)		t. INTERVAL BETWEEN ONSET AND DEATH	
u. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		v. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
w. 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		x. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Caused by fall from the staircase leading down</i>	
y. 20c. TIME OF INJURY Month, Day, Year Hour e. m. <i>Feb. 15 1958</i>		z. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <i>of work</i>	
aa. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>House</i>		bb. 20f. (City or town) <i>Hall P.S. Md.</i> (County) <i>Montgomery</i> (State) <i>Md.</i>	
cc. 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		dd. DATE SIGNED <i>Feb. 21, 1958</i>	
ee. ACTUAL SIGNATURE <i>James I. Boyd</i>		ff. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
gg. EXAMINER'S NAME (Type) <i>James I. Boyd</i>		hh. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
ii. 22a. BURIAL CREMATION, DATE THEREOF REMOVAL (Specify) <i>Burial Feb. 23, 1958</i>		jj. 22c. NAME OF CEMETERY OR CREMATORY <i>Edgar Yeshiva Cemetery</i>	
kk. 22d. LOCAT ON (City, town, or county) <i>Phila. Pa.</i> (State) <i>Pa.</i>		ll. 240. REC'D BY REGISTRAR <i>FEB 24 1958</i>	
mm. 23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Langenbach &amp; Sons - 3501 - 14th St. N.W.</i>		nn. 24b. REGISTRAR'S SIGNATURE <i>Quinton</i>	

BUREAU V. M.

FEB 9 4 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2350

## CERTIFICATE OF DEATH

Reg. Dist. No. 12307

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10908-Baltimore Ave.</b>		e. STREET ADDRESS <b>10908-Baltimore Ave.</b>			
f. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>FRED</b>	Middle <b>DOUGLAS</b>	Last <b>KING</b>		
4. DATE OF DEATH	Month <b>February</b>	Day <b>28</b>	Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March, 5, 1868</b>		
9. AGE (In years last birthday) <b>89</b>	10. IF UNDER 1 YEAR Months <b>89</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>		
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant</b>	14. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov. Farm</b>	15. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>	16. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
17. FATHER'S NAME <b>Unknown</b>	18. MOTHER'S MAIDEN NAME <b>Unknown</b>	19. ADDRESS <b>637-Girard St. N.E. Wash. D.C.</b>			
20. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, if known) <b>NO</b>	21. SOCIAL SECURITY NO. <b>NONE</b>	22. INFORMANT <b>Fred W. King</b>	23. INTERVAL BETWEEN ONSET AND DEATH <b>45 minutes</b>		
24. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary</b> DUE TO <b>45 minutes</b>		25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cardiac decompensation</b>			
26. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	27. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>1957</b>				
28. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	29. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	30. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>7600 Carroll Ave., Tak. Pk.</b>	31. (City or town) <b>Takoma Pk.</b>	(County) <b>Md.</b>	(State) <b>Md.</b>
32. I certify that I attended the deceased from <b>1957</b> , 19 <b>57</b> , to <b>Feb 24, 1958</b> , that I last saw the deceased alive on <b>Feb 24, 1957</b> , and that death occurred at <b>6:00 A.M.</b> from the causes and on the date stated above ACTUAL SIGNATURE <b>Raymond O. West</b> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <b>RAYMOND O. WEST</b> 7600 Carroll Ave., Tak. Pk. 22d LOCATION (City, town, or county) <b>Colmar Manor, Fr. Geo. Co. Md.</b> DATE SIGNED <b>2/28/1958</b>					
33. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	34. DATE THEREOF <b>3/3/1958</b>	35. NAME OF CEMETERY OR CREMATORIUM <b>Fort Lincoln Cemetery</b>	36. LOCATION (City, town, or county) <b>Colmar Manor, Fr. Geo. Co. Md.</b>		
37. FUNERAL DIRECTOR'S SIGNATURE <b>W.W.Chambers Co. 5801-Cleve. Ave.</b>	38. ADDRESS <b>RIVERDALE MD.</b>	39. REC'D BY REGISTRAR DATE <b>MAP 4 '58</b>	40. REGISTRAR'S SIGNATURE <b>Alfred</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 which is to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

GUEREAU V.

1944  
1945

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12398

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a Burial Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2310		2. USUAL RESIDENCE (Where deceased lived if institut. on Residence before admission)	
Prince Georges		MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY N 1b		b. COUNTY Pr. Geo.	
Riverdale		D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		X Beltsville College Park Md Post		d. STREET ADDRESS	
Leland Memorial Hospital		Canary Cottage Tailer Camp		e. SLEEP ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Georges	Middle Alfred	Last Joseph	DATE OF DEATH February 17	Month Year 1958
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1897	9. AGE (in years last birthday) 60 yrs	10. IF UNDER 18 YEARS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Supervisor Naval Gun Factory		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Thomas James King		14. MOTHER'S MAIDEN NAME Bridget C Mc Allister		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 1		16. SOCIAL SECURITY NO		17. INFORMANT Address Susan S. King, Beltsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute congestive heart failure			
44a X DUE TO Conditions, if any, which gave rise to immediate cause (a), stealing the underlying cause fast.		Cardiovascular renal disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2-17-58	
EXAMINER'S NAME (Type) John T. Maloney, M.D.					
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 20, 1958		22c. NAME OF CEMETERY OR INCINERATOR Arlington National	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		ADDRESS		24a. REC'D BY REGISTRAR FEB 20 '58	
				24b. REGISTRAR'S SIGNATURE <i>W. J. Reusch</i>	

BUREAU V.

TEB

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2311

## CERTIFICATE OF DEATH

(12399)

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10041 Baltimore Blvd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital, Inc.		d. STREET ADDRESS College Park, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Parnaby	Last Kitchen	4. DATE OF DEATH Sept. 18, 1885	Month February	Day 11	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1885	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY/ U.S.A.	
13. FATHER'S NAME James Arrowsmith				14. MOTHER'S MAIDEN NAME Lizzie Herner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  I		16. SOCIAL SECURITY NO.		17. INFORMANT John W. Kitchen College Park Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO		Cerebral Hemorrhage 3 days		INTERVAL BETWEEN ONSET AND DEATH 5 yrs - 10 yrs -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastritis		Gastritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gastritis					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County) (State)		
21. I certify that I attended the deceased from <u>21/10/1958</u> , and that I last saw the deceased alive on <u>21/10/1958</u> , and that death occurred at <u>21/10/1958</u> . M., from the causes and on the date stated above				ADDRESS (Street, city or town, state) Laurel, Md.			
ACTUAL SIGNATURE J. M. Warren				DATE SIGNED 10/21/1958			
PHYSICIAN'S NAME (Type) Burial		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/14/58	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) Colmar Manor, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Maryland		24a. REC'D BY REGISTRAR FEB 14 '58	24b. REGISTRAR'S SIGNATURE One /		

BUREAU W. S.

FEB 14 1963

MAILING

02310

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

2351

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] b. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>		c. LENGTH OF STAY IN 1b <b>6 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>	
3. NAME OF (Type or print) <b>Rita</b>		First <b>Irene</b>	Middle <b>Lam</b>
4. DATE OF DEATH	Month <b>February</b>	Day <b>20</b>	Year <b>58</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 14, 1957</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years (to birthday) yrs.) <b>1</b>
13. FATHER'S NAME <b>Oliver Lam</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mr. Oliver Lam, same as # 2</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Asphyxia</b>			
DUE TO <b>921.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <b>Due to aspiration of food</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. EXTERNAL CAUSE WAS PR.MARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Aspirated food while being fed by mother</b>	
20c. TIME OF INJURY Hour <b>12:00</b> a.m. <b>2/20/58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Brandywine</b> (County) <b>P.G.</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>James T. Boyd</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James T. Boyd</b>		DATE SIGNED <b>February 20, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/22/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Emmanuel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Horsehead Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros.—Upper Marlboro, Maryland</b>		ADDRESS	24a. REC'D BY REGISTRAR <b>FEB 25 '58</b>
			24b. REGISTRAR'S SIGNATURE <i>W. - 100-1</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial or removal.

VS. AISMES(S)  
SM 9/55

7. A. Панчо



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2276 CERTIFICATE OF DEATH

Reg. Dist. No.

112311

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived)		II institution		Residence before admission	
Prince Georges				a. STATE		Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Hyattsville		2 mos.		Arlington					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		d. STREET ADDRESS		871 No. Abington Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5301-41st Ave.									
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Margaret			McVey	Lowe	February		27	1958	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		W hite		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Dec 9, 1870		87 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Home Maker.				West Virginia		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
John McVey		Elizabeth Frances Cole							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
(If yes, give war or dates of service)		-		Mr Harold R. Little		2906 Bunker Hill Rd., Apt. 2B, Baltimore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Arterial Deterioris				unknown			
? 4 X DUE TO		Diseases.							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)							
DUE TO		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that I attended the deceased from Jan 16, 1958, to Feb 27, 1958, that I last saw the deceased alive on Feb 27, 1958, and that death occurred at 11 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE		CHARLES J. HOWNE M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type)		CHARLES J. HOWNE M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORI		22d. LOCATION (City, town, or county) (State)			
Removal		3/1/58		Restwood Cemetery		Hinton, West Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
The S. H. Hines Co.		Washington, D. C.		DATE MAR 3 '58		John Lewis			

BLÉAU V. 2



## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

12352

## CERTIFICATE OF DEATH

02312

Reg. Dist. No.

1. PLACE OF DEATH D. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Baltimore, Maryland		D. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
RURAL	12 yrs.	X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
	4930 PRINCE GEO AVE.		
3. NAME OF DECEASED (Type or print)	First ROSA	Middle E	Last LUCAS
4. DATE OF DEATH	Month FEB	Day 6	Year 1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 14-1878
F	W		9. AGE (In years lost birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Housewife.			Virginia
13. FATHER'S NAME		14. MOTHER'S MARRIED NAME	
Felix		NOT KNOWN.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
(If yes, give name or dates of service)		NONE	JESSE L. HUMPHREY.
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b)			
DUE TO			
Cerebral Hemorrhage 6 days			
Cerebral Arteriosclerosis			
Senility			
Shake			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/16/1957 to 2/7/1958 that I last saw the deceased alive on 2/2/1958, and that death occurred at 1145 M. from the causes and on the date stated above. ACTUAL SIGNATURE B. P. Warren M.D. ADDRESS (Street, City or town, state) Prince George Co. Md. DATE SIGNED 2/7/58			
PHYSICIAN'S NAME (Type) B. P. WARREN.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL
Burial		Feb. 10-1958	St. Lincoln
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR
K. Arthur Ballou		254 Carroll St. Baltimore, Md.	24b. REGISTRAR'S SIGNATURE C. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

EB 10 1968

BUREAU OF INVESTIGATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02313

2353

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 7 mos., & 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 4/1x			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 2132 N. St., N. W., #3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Louis	Middle E.	Last Mann	4. DATE OF DEATH 2	Month 2	Day 2	Year 19 58
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8/15/16	9. AGE (In years last birthday) 11 yrs	IF UNDER 1 YEAR Months — Days —	IF UNDER 24 HRS Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vendor		10b. KIND OF BUSINESS OR INDUSTRY Leon Smith, 807 25th St., N. W.	11. BIRTHPLACE (State or foreign country) Washington, D. C.	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Louis Perry		14. MOTHER'S MAIDEN NAME Blanche Mann					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-16-3122		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma involving lungs, pleura, DUE TO liver, peritoneum, adrenals, and abdominal and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) thoracic lymph nodes, primary site undetermined DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 2 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary tuberculosis; cirrhosis of liver							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)					
20c. TIME OF INJURY Hour a. p.m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Glenn Dale Hospital		(County)	(State)
21. I certify that I attended the deceased from 6/1/1957 to 2/2/1958, that I last saw the deceased alive on 3/2/1958, and that death occurred at 10:15 AM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Moe Weiss</i> M.D. DATE SIGNED 2/2/58 PHYSICIAN'S NAME (Type) Moe Weiss, M. D. Glenn Dale, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/6/58		22c. NAME OF CEMETERY OR CREMATORIAL Lincoln Mem.		22d. LOCATION (City, town, or county) Scotland Rd. Ind.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Boyd</i>		ADDRESS 1238. 20th St. N.W.		24a. REC'D BY REGISTRAR FEB 5 '58		24b. REGISTRAR'S SIGNATURE <i>Alfredus</i>	

BUREAU V. S.

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

112314

2354

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH

o. COUNTY

PRINCE GEORGE

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hillside

c. LENGTH OF STAY IN 1b  
RURAL and give nearest town)

38 yrs

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

5312 "O" Street

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)

o. STATE

MARYLAND

b. COUNTY

PRINCE GEORGE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

HILLSIDE

d. STREET ADDRESS

5312 O ST. S.E.

e. IS RESIDENCE  
ON A FARM?YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS

Days

Hours

Min

FEMALE

White

WIDOWED  DIVORCED 

FEB. 8 1884

74 1/2 yrs.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

47-TIRED

HOUSEWORK.

ITALY

U.S.A.

13. FATHER'S NAME

(Unknown) Grasso

14. MOTHER'S MAIDEN NAME

(Unknown) Grasso

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(If yes, give war or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

ANGELO MARLETTA 5312 O ST. S.E.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a)

Bronchopneumonia

INTERVAL BETWEEN  
ONSET AND DEATH

1 week

450.0

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

Generalized Arteriosclerosis &amp; Senility

5 yrs.

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

471X

19. WAS AUTOPSY  
PERFORMED?YES  NO 

20a. MEDICAL CERTIFICATION

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m.  
p. m.20d. INJURY OCCURRED  
While  
at work  Nat while  
at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)20f. (City or town)  
(County) (State)

21. I certify that I attended the deceased from 2-6, 1958 to 2-12, 1958 that I last saw the deceased

alive on 2-10, 1958, and that death occurred at 9:50 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATUREPHYSICIAN'S  
NAME (Type)

John P. O'ANGELD 4223 Silver Hill Rd., Silver Hill, Md.

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

2-15-58

22c. NAME OF CEMETERY OR CREMATORIUM

Cedar Hill Dem.

22d. LOCATION (City, town, or county) (State)

Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

Lee Funeral Home - 11 cash. 20

ADDRESS

24a. REC'D BY REGISTRAR

FEB 14 '58

DATE

24b. REGISTRAR'S SIGNATURE

An.. eueh

REGRADING

EB 14 3 5

REGULATING

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02315

Reg. Dist. No.

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed in my presence, writing the word "pending" in parentheses above "Cause of Death" if it is to be forwarded to the Chief Medical Examiner's Office. Page 3 should be used as a burial permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland c. COUNTY Prince George's	
Prince George's MARYLAND Cheverly Dead on arrival		Fairmont Heights STREET ADDRESS 720 60th Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dennis		First Massey	MIDDLE Month Year
4. DATE OF DEATH February 16 1958		Last Month Year	Month Day Year
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 15, 1957	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James P. Cannon		14. MOTHER'S MAIDEN NAME Pearl Massey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I: DEATH WAS CAUSED BY FURTHER ST. OF CAUSE (o)  DUE TO  Conditions: If any, which gave rise to immediate cause (o), stating the underlying cause lost. (b)  DUE TO (c)		Lobar pneumonia	
19. INTERVAL BETWEEN ONSET AND DEATH INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ACTUAL SIGNATURE <i>James I. Boyd</i>		DATE SIGNED February 16, 1958	
EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) 2-20-58		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn	
23. FUNERAL DIRECTOR'S SIGNATURE H. W. Washington & Sons		22d. LOCATION (City, town, or county) Baltimore Md. St. 10c.	
ADDRESS 467 N St. N.W. Wash. D.C.		24a. REC'D BY REGISTRAR FEB 21 '58	
VS. AT 5ME 5M 2 '57		24b. REGISTRAR'S SIGNATURE <i>C. C. C.</i>	

BUREAU V. S.

FEB

REGISTRATION

02316

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Item 2355 1m G-2.6 3/3/58.cac

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PPA3. Page 5 may be retained by your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Virginia b. COUNTY	
Prince George's MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Transient Charlotte Court House	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) T. B.		d. STREET ADDRESS None	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 381 and Floral Park Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel Saunders		First	Middle
		McAdoo	Last
3. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> May 15, 1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY L.M. Lindsay Lumber Co. Saw Mill Co.	
10c. BIRTHPLACE (State or foreign country) N. C.		9. AGE (In years last birthday) 49 yrs.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Leola Murray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or date of service)		16. SOCIAL SECURITY NO 241-12-8070 17. INFORMANT Doris Terry - Daughter Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Laceration of the Aorta, rupture of the spleen (c) Fracture of the left femur, laceration of the scalp			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRINCIPAL or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) Pedestrian in auto accident (hit and run) (M.V. Comm)	
20c. TIME OF INJURY Month, Day, Year Hour o. m 2/3/1958		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 381 T. B. (County) Pr. Geo. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED February 4/1958	
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/1958	
22c. NAME OF CEMETERY OR CREMATORIUM St. Louis Cemetery		22d. LOCATION (City, town, or county) Charlotte Court House, Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 901 3rd St., S. W.		24a. REC'D. BY REGISTRAR FEB 7 1958 24b. REGISTRAR'S SIGNATURE O. L. Hall	
VS. A15ME SM 2/57		DATE	

BUREAU V. S.

FEB 7 1933

POLICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2356

Reg. No. 02605

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMS. Page 5 may be retained in your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)	
Prince George Maryland		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Prince George	
Forestville 6 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTIONS (If not in hospital, give street address)		d. STREET ADDRESS Forestville	
3304 Wintergreen Ave		e. IS THERE FENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
Ralph Edgar Mc Clonahan		First	Middle
Male White		Lost	Month Day Year
5. SEX		6. COLOR OR RACE	
6. COLOR OR RACE		7. MARRIED	
White		NEVER MARRIED <input type="checkbox"/>	DATE OF BIRTH
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
8. AGE (In years last birthday)		9. IF UNDER 1 YEAR IF UNDER 24 HRS.	
30 yrs.		Months	Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Mechanic		Capitol Supply Co Virginia	
13. FATHER'S NAME		14. MOTHER'S MARRIED NAME	
Mertie Edgar Mc Clonahan		Maud Estelle Clem	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT	
No		Mertie Mc Clonahan Westmoreland, Va	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		Address 423 3rd St. before	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Hemorrhage and shock			
9 1/2 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) DUE TO Gun shot wound of head			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
House 7:05 a.m. 2-27 1958		Shot self in head	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED	
at work <input type="checkbox"/> Not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
Forestville		Md.	
27. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE: James T. Boyd		DATE SIGNED: 2-28-58	
EXAMINER'S NAME (Type): James T. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		3-3-58	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)	
Massachusetts		Woodstock Va	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
James T. Boyd, Jaschens Sons Hyattsville, Md.		24b. REGISTRAR'S SIGNATURE	
		MAR 3 '58 Allie Beach	

BUREAU V. S.

12 1938  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2313

## CERTIFICATE OF DEATH

Reg. Dist. No.

112317

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>	c. LENGTH OF STAY IN 1b <i>7 days</i>	b. COUNTY <i>Prince George</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Helund Memorial Hosp</i>	14. STREET ADDRESS <i>7400 Dartmouth St. c.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <i>Henry</i>	Middle <i>B.</i>	Last <i>McDonnell</i>	4. DATE OF DEATH <i>Feb. 7 1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-31-1863</i>	9. AGE (In years lost birthday) <i>94 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Professor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Medical Record</i>		11. BIRTHPLACE (State or foreign country) <i>Penns.</i>

12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>David McDonnell</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth Cross</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>Address</i>	17. INFORMANT <i>Hospital Record</i>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH
Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>	<i>3 wks</i>
332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>UREMIA</i>	<i>4 dys</i>
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>GENERALIZED Arteriosclerosis</i>	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	--	---

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Feb 7 1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>FEB</i>	20f. (City or town) <i>(County)</i>	(State)
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21. I certify that I attended the deceased from <i>JAN 10 1958</i> , to <i>FEB 7 1958</i> , that I last saw the deceased alive on <i>FEB 7 1958</i> , and that death occurred at <i>9:45 P.M.</i> from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <i>Colmar Manor, Maryland</i>	DATE SIGNED <i>2/7/58</i>
---	--	------------------------------

ACTUAL SIGNATURE <i>W. Etienne</i>	PHYSICIAN'S NAME (Type) <i>W. ETIENNE</i>
---------------------------------------	--

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>Feb 10, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Port Lincoln Crematory</i>	22d. LOCATION (City, town, or county) <i>Colmar Manor, Maryland</i>
---	--	---	--

23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>	ADDRESS <i>Hyattsville, Md.</i>	24a. REC'D BY REGISTRAR <i>Feb 11 1958</i>	24b. REGISTRAR'S SIGNATURE <i>W. Etienne</i>
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Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be furnished page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRUNAU V. S.  
1928  
LICENCIENCE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2277

## CERTIFICATE OF DEATH

Reg. Dist. No. 02315

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>D.C.</u>		b. COUNTY <u>WASH. D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>7 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH. D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOME</u>		d. STREET ADDRESS <u>1736 COL. RD. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>Katherine</u>	Middle <u>T. Merrick</u>	Last <u></u>	4. DATE OF DEATH <u>February</u>	Month <u>3</u>	Day <u>19</u>	Year <u>58</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <u>MAR. 10. 1872</u>	9. AGE (in years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u></u>	IF UNDER 24 HRS Days <u></u>	Hours <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE MERRICK</u>		14. MOTHER'S MAIDEN NAME <u>ALICE WARING</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Home Records</u>		Address <u></u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO <u>446X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Glomerulonephritis, chronic</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> 20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 22, 1957</u> , to <u>Feb. 3, 1958</u> that I last saw the deceased alive on <u>Jan 31, 1958</u> , and that death occurred at <u>5:20 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Thomas F. Collins</u>		ADDRESS (Street, city or town, state) <u>H St. N.E.</u>		DATE SIGNED <u>Feb. 3 1958</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS F. COLLINS</u>		Washington D.C.		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Feb. 5, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>M.T. CARMEL</u>		22d. LOCATION (City, town, or county) <u>Upper MARLBRO.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. TALIAFULE</u>		24a. REC'D. BY REGISTRAR <u>FEB 4 1958</u>	
ADDRESS <u>3603 14th ST. NW</u>		(State) <u>MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Alt. search</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PAUL V. S.

3 a 190



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2357

## CERTIFICATE OF DEATH

12319

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Pr George's County</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <i>Rural Forestville</i>		c. LENGTH OF STAY IN 1b <i>18 Yrs</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>maryland</i>		b. COUNTY <i>Pr. Deos</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Forestville</i>		f. STREET ADDRESS <i>Westphalia Road</i>		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Daniel Edgar Moore</i>		First	Middle	Last	4. DATE OF DEATH <i>Feb 8</i>	Month	Day	Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 1st 1847</i>		9. AGE (In years last birthday) yrs <i>80</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tobacco Farm</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Spencer Moore</i>		14. MOTHER'S MAIDEN NAME <i>MARY Phillips</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Leta Moore, Upper Marlboro Md RFD#1</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>420.0</i>		DUE TO <i>Coronary Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>6 Days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) } DUE TO } (c)		Coronary Insufficiency		Arteriosclerotic Heart Disease		}			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p.m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Farmville</i>		20f. (City or town) <i></i>		(County)	(State)
21. I certify that I attended the deceased from <i>Jan 15</i> , 19 <i>50</i> , to <i>Feb 8</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Feb 3</i> , 19 <i>58</i> , and that death occurred at <i>5:00 PM</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i></i>		DATE SIGN'D <i>2/13/58</i>	
ACTUAL SIGNATURE <i>W. Suit Pritchie</i>		M.D. <i>7005 Pritchie Rd SE Wash 20021</i>							
PHYSICIAN'S NAME (Type) <i>W. Suit Pritchie M.D.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11 Feb 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Farmville</i>		22d. LOCATION (City, town, or county) <i>Farmville North Carolina</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>KWA/111 FUNERAL HOME</i>		ADDRESS <i>816-647 NE</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 13 '58</i>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SAU Y. S.

1958

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2314

## CERTIFICATE OF DEATH

(12320)

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>		c. LENGTH OF STAY IN 1b <b>11 Hrs. 40 Min</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH J MULKERINS</b>		d. STREET ADDRESS <b>5205 Baltimore Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
S SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 July 1957</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Brian Mulkerins</b>		14. MOTHER'S MAIDEN NAME <b>Margaret L. <del>Deitz</del> Beacons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>- - - - -</b>	
17. INFORMANT <b>Joyce Deitz, Vice President</b>		Address <b>5205 Baltimore Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>492 X</b>		INTERVAL BETWEEN ONSET AND DEATH <b> </b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b> </b>		DUE TO <b> </b>	
(c) <b> </b>		DUE TO <b> </b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>27 Feb 1958</b> to <b>27 Feb 1958</b> , that I last saw the deceased alive on <b>27 February 1958</b> , and that death occurred at <b>11:00PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Aaron Deitz</b>		ADDRESS (Street, city or town, state) <b>1430 Bellona Ave</b>	
PHYSICIAN'S NAME (Type) <b>AARON DEITZ, M.D.</b>		DATE SIGNED <b>22857</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>3/3 58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Crown Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.R. Huntzinger &amp; Son</b>		24a. REC'D BY REGISTRAR DATE <b>4 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Alfred Deitz</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.  
**M**  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12321

Reg. Dist. No.

TO DEATH MEDICAL EXAMINER: This certificate should be executed with 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN lb <b>10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5508 43rd Place</b>		e. STREET ADDRESS <b>5508 43rd Place</b>		f. IS REL. DEFN. ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Michael Patrick Murphy</b>		First	Middle	Last	4. DATE OF DEATH <b>February 4th 1958</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <b>WIDOWED</b>	8. EVER MARRIED DIVORCED <b>DIVORCED</b>	9. DATE OF BIRTH <b>8-1-15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Upholstery</b>		11. BIRTHPLACE (State or foreign country) <b>Jonesboro Louisiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>J. P Murphy</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO <b>W W 11 433-12-0731</b>		17. INFORMANT <b>Nancy Brown Murphy</b>	
				510 Bailey St Haynesville, Louisiana	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion			
DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.		Coronary Sclerosis			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>February 4, 1958</b>	
NAME (Type) <b>John T. Maloney, M.D.</b>		22b. DATE THEREOF <b>2/5/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Hope</b>	
22a. BURIAL OR CREMATION REMOVED Transportation		22d. LOCATION (City, town, or county) <b>Arkansas</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 7 1958</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. E. Deuch</b>	

BUREAU Y.

FEB 7 1958

SEARCHED  
INDEXED  
SERIALIZED  
FILED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02322

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

REPUTED MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial (rental) permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2315 Prince George's MARYLAND		3. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		b. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb Dead on arrival		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS 2715 Nicholson Street	
Cheverly				West Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RE. DENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Prince George's General Hospital							
3. NAME OF DECEASED (Type or print)		First Della	Middle Marie	Last Nellis	4. DATE OF DEATH February 16	Month 19	Day 58
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED	8. DATE OF BIRTH 8/23/11	9. AGE (In years last birthday) 46	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
7. MARRIED NEVER MARRIED Married DIVORCED					Yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Waitress Food		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Raymond Mason		14. MOTHER'S MAIDEN NAME Hattie Grace Richareson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Olive Matera, 5914 27th Avenue Address Hilcrest Heights, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerosis DUE TO (c) Cirrhosis of the liver  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) BETWEEN ONSET AND DEATH							
20c. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE  EXAMINER'S NAME (T. pe.) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED February 16, 1958			
22a. BURIAL, CREMATION REMOVAL (Specify) Feb. 19, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Washington National		22d. LOCATION (City, town, or county) Suitland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS - Washington D.C.		24a. REC'D BY REGISTRAR FEE 21 '58		24b. REGISTRAR'S SIGNATURE O. Leesuk	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2316 CERTIFICATE OF DEATH

112323

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE	
<i>Pierce George</i> MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly 2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>mitchellville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Pr. Geo's Gen. Hospital</i>		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Mrs Ether Lucrecia</i>	Middle <i>Owens</i>	Last
4. DATE OF DEATH	Month <i>Feb</i>	Day <i>1</i>	Year <i>1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 30, 1921</i>
9. AGE (In years lost birthday) <i>34 yrs</i>	10. IF UNDER 1 YEAR Months <i>3</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Employd Stenographer Health Dept.</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>County</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Walter Thomas Nicholson</i>	14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Cranford</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>— 000 — 000</i>	17. INFORMANT <i>Randolph Owens husband</i>	Address <i>MITCHELVILLE, MD.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sub arachnoid hemorrage</i>		<i>2 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Ruptured Aneurysm of Circle of Willis</i>		<i>2 days</i>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1/30</i> , 1958, to <i>2/1</i> , 1958, that I last saw the deceased alive on <i>2/1</i> , 1958, and that death occurred at <i>4:50 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>3503 Penny St</i>	
ACTUAL SIGNATURE <i>Norman Donati Bomeru</i>		DATE SIGNED <i>2/1/58</i>	
PHYSICIAN'S NAME (Type)		<i>Norman Donati Bomeru</i> M.D. <i>MT Rainier MD</i>	
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/4/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Washington National Cem. Suitland</i>	22d. LOCATION (City, town, or county) (State) <i>Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Boos, Upper Marlboro, Md.</i>	ADDRESS <i>16th &amp; Main St</i>	24a. REC'D BY REGISTRAR <i>Feb 10 '58</i>	24b. REGISTRAR'S SIGNATURE <i>D. L. Smith</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

BUREAU V. S

1958

GENERAL

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

102324

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained by your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND <b>2358</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Heights Forest</b>		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forest Heights</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>112 Huron Street</b>				d. STREET ADDRESS <b>112 Huron Street</b>	
3. NAME OF DECEASED (Type or print) <b>Linda</b>		First <b>Carol</b>	Middle <b>Parnell</b>	Last <b>2</b>	4. DATE OF DEATH Month <b>15</b> Year <b>1958</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 1957</b>	9. AGE (In years last birthday) yrs. <b>22</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>	
13. FATHER'S NAME <b>Donald Wayne Parnell</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Simpson</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs Thomas H. Parnell</b> Address <b>300 Woodland Drive</b> <b>Forest Heights, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>34.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b) DUE TO  (c) DUE TO		Acute pulmonary edema  Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE  <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>February 16, 1958</b>	
22a. BURIAL, CREMATION, ETC. DATE THEREOF REMOVAL (Specify) <b>Burial Feb 18-58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) <b>Woodland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE  <b>Simmons Bros</b>		ADDRESS <b>1661 Belvoir Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 20 '58</b>	
9VVVVVVVVXVV				24b. REGISTRAR'S SIGNATURE <b>W. L. Leach</b>	

BUREAU V. S.

FEB 20 1968

REGULATIVE

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 112325

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived - If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL give nearest town)		c. LENGTH OF STAY IN 1b Fort Foote 16 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Foote	
f. STREET ADDRESS 7105-Open Hill Rd		g. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillian Martin Pace		4. DATE OF DEATH Year Month Day Year 1895 Feb 9 1958	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 20, 1895	
9. WIDOWED <input checked="" type="checkbox"/>		10. DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Gentlewoman	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Henry Martin		14. MOTHER'S MAIDEN NAME Ruth Webster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Ruth Webster Thorne, Fort Foote		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44dx DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebrovascular accident</u> (c) <u>Cardiovascular renal disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James J. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-12-58	
22c. NAME OF CEMETERY OR CREMATORIUM Arlington Natl.		22d. LOCATION (City, town, or county) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Hennings Bros.		ADDRESS 1661 Good Hope Rd. N.E. Wash. D.C.	
24a. REC'D BY REGISTRAR Date 11 '58		24b. REGISTRAR'S SIGNATURE John E. Smith	

СИБУР Y. S

СИБУР

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2360 CERTIFICATE OF DEATH**

112326

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
<i>Funie George</i> MARYLAND		<i>Maryland</i> <i>Funie George</i> , b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Saint Knights - Funie George</i>		<i>Saint Knights - Funie</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>72-73-Walkers Mill Rd.</i>		<i>72-73 Walkers Mill Rd.</i>	
e. LENGTH OF STAY IN 1b		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print)		First	Middle
<i>JOSEPH</i>		<i>ANTHONY</i>	<i>PESAGNO</i>
4. DATE OF DEATH		Month	Day
		<i>Feb.</i>	<i>1</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>Male</i>		<i>White</i>	
8. DATE OF BIRTH		9. AGE (In years from last birthday)	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
<i>Aug. 17, 1892</i>		<i>65 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Amerson Company</i>		<i>Waugh</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>America</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Anthony Peasey</i>		<i>Amelia Rettagliata</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT	
<i>yes</i>		<i>705-12-5774</i> <i>J. A. Peasey</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>coronary thrombosis</i>	
4.001 DUE TO		<i>24 hours</i>	
Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause lost.		(b)	
DUE TO			
		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>Feb. 1</i> , 1958, to <i>Feb. 1</i> , 1958, that I last saw the deceased alive on <i>Feb. 1</i> , 1958, and that death occurred at <i>4127 Central Ave.</i> , M, from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
<i>William Brainin</i> M.D.		<i>4127 Central Ave.</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>2/1/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/5/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National</i>		22d. LOCATION (City, town, or county) <i>Arlington, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James T. Ryan, Inc.</i>		24a. REC'D BY REGISTRAR <i>EBE</i>	
ADDRESS <i>317 Pa. Ave., S.E.C.</i>		24b. REGISTRAR'S SIGNATURE <i>EBE</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

SUREAU V. S.

7 - 1928

MCGEIVY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2317

## CERTIFICATE OF DEATH

Reg. Dist. No.

112327

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accokeek</b>		d. STREET ADDRESS <b>Rte 1 Box 9</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				e. IS RESIDENCE ON A FARM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Lelia</b>	Middle <b>J</b>	Last <b>Peterson</b>	4. DATE OF DEATH	Month <b>2</b>	Day <b>17</b>	Year <b>1958</b>
5. SEX	6. COLOR OR RACE <b>Female</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 13, 1906</b>	9. AGE (In years last birthday) <b>51 yrs</b>	10. IF UNDER 1 YEAR Months <b>5</b>	Days <b>5</b>	11. IF UNDER 24 HRS Hours <b>8</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ROBERT LEE BUTLER</b>		14. MOTHER'S MAIDEN NAME <b>SARAH L MOULDEN</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>DAVID R PETERSON</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 mo.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>153.8</b>		Car conomatasis of abdomen		DUE TO <b>Ca of Colon</b>		2. yes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Febr. 6, 1958</b> to <b>Febr. 12, 1958</b> , that I last saw the deceased alive on <b>February 16, 1958</b> , and that death occurred at <b>10:10 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Hans Wodak</b> M.D. <b>30-C Bridge Rd, Gaithersburg, Maryland</b> DATE SIGNED <b>May 2-1958</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-24-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National</b>		22d. LOCATION (City, town, or county) <b>77 singer, Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Jr.</b>		ADDRESS <b>3072 M ST NW</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. W. Chambers Jr.</b>	

BERLIAU V. S

123

RECOLVIE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2318 CERTIFICATE OF DEATH

Reg. Dist. No. 1232

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverl</b>		c. LENGTH OF STAY IN 1b <b>1 hr</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>8780 New Fort Wash. Rd.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Noah</b>	Middle <b>C</b>	Last <b>Pool</b>	4. DATE OF DEATH Month <b>Feb</b>	Day <b>5</b>	Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-8-1920</b>	9. AGE (In years lost birthday) yrs <b>73??</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Pool</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Jane Pool 7132 Falmer Id. Wash. D.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH 1 week 3 years 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 10.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 2, 1957</b> to <b>February 4, 1958</b> , that I last saw the deceased alive on <b>Feb. 4, 1958</b> , and that death occurred at <b>150</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Hans Wodak</b>		ADDRESS (Street, city or town, state) <b>30 C Ridge Rd., Frederick, Md.</b>					
PHYSICIAN'S NAME (Type) <b>Dr. H. Wodak MD</b>		DATE SIGNED <b>2-4-58</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-7-1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gerald Abuttingly</b>		ADDRESS <b>131-11 31st St. Wash. D.C.</b>					
		24a. REC'D BY REGISTRAR <b>FEB 7</b>					
		24b. REGISTRAR'S SIGNATURE <b>Q. J. Smith</b>					
		DATE					

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2319 CERTIFICATE OF DEATH**

Reg. Dist. No. **i1232**

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>		c. LENGTH OF STAY IN lb. <b>adm. 11-30-1950</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LAUREL SANITARIUM</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
3. NAME OF DECEASED (Type or print) <b>BESSIE</b>		First <b>BESSIE</b>	Middle <b>PORTER</b>
4. DATE OF DEATH <b>2</b>		Month <b>2</b>	Day <b>13</b>
		Year <b>1958</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>10-29-1871</b>		9. AGE (In years from birthday) <b>86</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>86</b> Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>BENJAMIN BUCK PORTER</b>		14. MOTHER'S MAIDEN NAME <b>VIRGINIA REID</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Hospital Records, Laurel Sanitarium, Laurel MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL Embolism and Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis with psychotic reaction</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>one week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2 Dec 1 - 1956</b> to <b>2-13-1958</b> , that I last saw the deceased alive on <b>2-13-1958</b> , and that death occurred at <b>4:30 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>LAUREL SANITARIUM</b> DATE SIGNED <b>2-13-58</b>	
ACTUAL SIGNATURE <b>Erika P. Kraemer</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Erika P. KRAEMER</b>		LAUREL, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>Feb 1st 1958</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Green Mount</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b> (State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Seward W. Johnson Jr.</b>		ADDRESS <b>108 W. Walsh</b>	
		24a. REC'D BY REGISTRAR <b>Dated 1</b>	
		24b. REGISTRAR'S SIGNATURE	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS #15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(02330)

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>45 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Huntsville</b>	
f. STREET ADDRESS <b>1204 70th Avenue</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary</b>		4. DATE OF DEATH <b>February 9, 1958</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>colored</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-1-1937</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Clinton Proctor</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Savoy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>111-11-1111</b>	
17. INFORMANT <b>James H. Proctor; Same address as # 2.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exhaustion</b>			
DUE TO <b>916.0</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Toxemia</b>			
DUE TO (c) <b>2nd and 3rd degree burns of 95% of body.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Clothing caught fire in home</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>6:45 p.m. 12-26-57 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Huntsville</b>		(County) <b>Pr. Geo.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED <b>February 9, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, Md.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
220. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-11-58</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>MT. Olivet</b>		22d. LOCATION (City, town, or county) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Myrtle L. Bellens #339 Hunt P.M.</i>		24a. REC'D BY REGISTRAR <b>FEB 13 '58</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	

BUREAU Y.

103



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2361 CERTIFICATE OF DEATH**

Reg. Dist. No.

112331

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Prince Georges Maryland</i>		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Rural 40 yr</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS <i>x Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>(Home)</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>Bry 133 Bowie, Md</i>	
3. NAME OF DECEASED (Type or print)	First <i>Jnez</i>	Middle <i>Edith</i>	Last <i>Praut</i>
4. DATE OF DEATH	Month <i>Feb</i>	Day <i>19</i>	Year <i>1955</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 31 1895</i>
9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months <i>6</i>	11. IF UNDER 24 HRS. Days <i>2</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Education</i>	
11. BIRTHPLACE (State or foreign country) <i>Georgia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Woodson</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-22-7128</i>	
17. INFORMANT <i>William O. Praut</i>		Address <i>Bowie, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>	
DUE TO { (b) <i>Hypertension</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cardiac Decompensation</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sep 2</i> , 1956, to <i>Feb 6</i> , 1957, that I last saw the deceased alive on <i>Feb 18</i> , 1958, and that death occurred at <i>7 a.m.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Henry D. Wise Jr. M.D.</i>		ADDRESS (Street, city or town, state) <i>Bowie, Md.</i> DATE SIGNED <i>2/19/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-22-58</i>	
22c. NAME OF CEMETERY <i>ASCENTION CATHOLIC CHURCH</i>		22d. LOCATION (City, town, or county) <i>BOWIE, MARYLAND</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Minn</i>		24a. REC'D BY REGISTRAR <i>1020-9</i>	
		24b. REGISTRAR'S SIGNATURE <i>John W. Minn</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 24 1958

BUREAU V. S.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

112332

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the ~~same~~, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

1. PLACE OF DEATH a. COUNTY		2362 Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 16  Avondale 3 months		d. STATE Maryland b. COUNTY Pr. Geo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Carroll Manor, 4922 La Salle Road					
3. NAME OF DECEASED (Type or print) Nellie		First	Middle	Last	4. DATE OF DEATH February 28 1958
5. SEX Female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 11-30-86 1879	9. AGE (in years or by birthday 78 yrs	10. IF UNDER 1 YEAR Months Days Hours M.M.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Edward Ready		14. MOTHER'S MAIDEN NAME Catherine Walsh		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Rev. Samuel R. Pitts; Georgetown University Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (b) Hypertensive heart disease. (a), stating the underlying cause lost. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED February 28, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3-3-58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	
22d. LOCATION (City, town, or county) Washington DC (State)					
23. FUNERAL DIRECTOR'S SIGNATURE H. W. DeVol - 24 Wis. Ave.		ADDRESS		24a. REC'D BY REGISTRAR MAR 4 '58	
				24b. REGISTRAR'S SIGNATURE	

BUREAU U. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

112333

2321

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE Maryland b COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 25	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Reed		4. DATE OF DEATH Feb 13, 1958.	Month Day Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 15, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motion Picture Operator		10b. KIND OF BUSINESS OR INDUSTRY N P A A	11. BIRTHPLACE (State or foreign country) Washington D. C.
13. FATHER'S NAME George Reed		14. MOTHER'S MAIDEN NAME Bessie Lee Forney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO 578 03 0187	17. INFORMANT Marie C Reed Address Riverdale,
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause(s), stating the underlying cause last. (b) _____ DUE TO (c) _____  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m.	Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JULY 1945</u> to <u>FEB. 13, 1958</u> , that I last saw the deceased alive on <u>2-13, 1958</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>4314 - GALLATIN ST.</u> DATE SIGNED <u>4-1-58</u>			
ACTUAL SIGNATURE <u>A. Deitz</u> PHYSICIAN'S NAME (Type) <u>AARON DEITZ M.D.</u> HYATTSVILLE, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 17, 1958</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town or county) <u>Suitland, Md.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	24a. REC'D BY REGISTRAR <u>RECEIVED 1-15-58</u> DATE
			24b. REGISTRAR'S SIGNATURE <u>John J. Deitsch</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shall be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RUMEAU V. S.

1958



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2363

## CERTIFICATE OF DEATH

Reg. Dist. No.

112334

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>D. C.</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>7 yrs., 1 mo &amp; 25 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>2012 North Capitol St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Jack</b>	First	Middle <b>F.</b>	Last <b>Reese</b>	4. DATE OF DEATH <b>2 2 19 58</b>	Month	Day	Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>Separated</b>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/30/1891</b>	9. AGE (in years last birthday) yrs. <b>66</b>	10. IF UNDER 1 YEAR Months <b>—</b>	11. IF UNDER 24 HRS. Days <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe coverer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carey Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John F. Reese</b>				14. MOTHER'S MAIDEN NAME <b>Helen Wilbert</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>128-07-1720</b>		17. INFORMANT <b>Decedent</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive and arteriosclerotic heart disease</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary tuberculosis; pulmonary emphysema; chronic cor pulmonale</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. n. p. m.	Month <b>19</b>	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>—</b>	(County) <b>—</b>	(State) <b>—</b>
21. I certify that I attended the deceased from <b>12/8</b> , 19 <b>50</b> , to <b>2/2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>12/2</b> , 19 <b>58</b> , and that death occurred at <b>7:25 PM</b> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Moe Weiss</i>	ADDRESS (Street, city or town, state) <b>Glenn Dale Hospital</b>				DATE SIGNED <b>2/2/58</b>			
PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>	Glenn Dale, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>Feb 5, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Washington, D.C.</b>				22d. LOCATION (City, town, or county) <b>(State)</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis J. Collins</i>		ADDRESS <b>3821 14TH Street NW</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 7 '58</b>		24b. REGISTRAR'S SIGNATURE <i>John L. Smith</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. L.

FEB 7 1953

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2364 CERTIFICATE OF DEATH

Reg. Dist. No.

02335

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 7 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN lb 2 mos., & 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
f. STREET ADDRESS 1238 W. St., S. E.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Elizabeth M.	Middle	Last Reynolds
4. DATE OF DEATH	Month 2	Day 12	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/87
9. AGE (In years lost birthday) 70 yrs		10. IF UNDER 1 YEAR Months — Days —	11. IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child Care		10b. KIND OF BUSINESS OR INDUSTRY —	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mack McKinley		14. MOTHER'S MAIDEN NAME Emily Hill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-24-4430	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 595 X DUE TO Pulmonary fibrosis, etiology undetermined		INTERVAL BETWEEN ONSET AND DEATH 1½ yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) For pulmonary, aortic stenosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/26, 1957, to 2/12, 1958, that I last saw the deceased alive on 2/12, 1958, and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Moe Weiss</i>	M.D.	Glenn Dale Hospital 2/12/58	
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.	Glenn Dale, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/15/58	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill	22d. LOCATION (City, town, or county) Brentwood Md.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Washington DC,	ADDRESS	24a. REC'D BY REGISTRAR DATE 1/15/58	24b. REGISTRAR'S SIGNATURE D. L. Clark

LEWIS V. S.

FEB 14



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

112336

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b> d. STREET ADDRESS <b>4121 4th Street</b>		Reg. Dist. No. <b>Pr. Geo.</b>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				f. DATE OF DEATH <b>February 9, 1958</b>
3. NAME OF DECEASED (Type or print)	First <b>Hattie</b>	Middle <b>Belle</b>	Last <b>Riles</b>	Month Year
4. SEX <b>Female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2-8-80</b>	9. AGE (In years less birthday) <b>78</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles Henry Riles</b>		14. MOTHER'S MAIDEN NAME <b>Virginia (last name unknown)</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Edward C. Riles; same address as # 2.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Hour e. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		DATE SIGNED <b>February 9, 1958</b>		
22a. BURIAL/CREMATION: REMOVAL (Specify) <b>2-15-58</b>	22b. DATE THEREOF <b>EVERGREEN</b>	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) <b>Bladensburg Md</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry Washington &amp; Sons</i>		ADDRESS <b>467 N St NW Wash D.C.</b>	24a. REC'D BY REGISTRAR <b>Feb 13 '58</b>	24b. REGISTRAR'S SIGNATURE <i>John T. Maloney</i>

BUREAU V. S.

EN 4 1959



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2279 CERTIFICATE OF DEATH

Reg. Dist. No. (12337)

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) b. STATE	
<i>Prince George</i> <i>Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Rainier</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Rainier</i>		c. LENGTH OF STAY IN 1b <i>35 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3405 Eastern Ave.</i>		d. STREET ADDRESS <i>3405 Eastern Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Rena</i>		First <i>Rena</i>	Middle <i>Blanche</i>
4. DATE OF DEATH <i>Feb 10 1958</i>		Month <i>Feb</i>	Day Year <i>10 1958</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>11 Feb 1876</i>		9. AGE (In years last birthday) yrs. <i>81</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>John West Ritchie</i>		14. MOTHER'S MAIDEN NAME <i>Georgia Anna Dwyer</i> Address	
15. HAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, or unknown) <i>No</i>		16. SOC. SECUR. NO <i>None</i>	
17. INFORMANT <i>Wife Gladys A. Davis</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute heart failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Generalized arteriosclerosis</i> (b) DUE TO <i>7 yrs</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>2200 R.T. Avenue</i>	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Wash. D.C.</i>	
ACTUAL SIGNATURE <i>Thomas E. Mettingly</i>		DATE SIGNED <i>10 Feb 58</i>	
PHYSICIAN'S NAME (Type) <i>Thomas E. Mettingly</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/13/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) <i>Bladensburg, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ritchie Bros. Funeral Home—Upper Marlboro</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 16 58</i>	
		24b. REGISTRAR'S SIGNATURE <i>John E. Mettingly</i>	

BUTTAU V. S

FEB 10 1970



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2323

## CERTIFICATE OF DEATH

Reg. Dist. No.

112335

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4901 Riverdale Road		d. STREET ADDRESS 4901 Riverdale Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Rachael	Middle Grace	Last Ryland
4. DATE OF DEATH	Month Feb	Doy 24,	Year 1958
5. SEX female	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1909
9. AGE (In years lost 28 yrs.)		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Oklahoma
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Walter Boz arth		14. MOTHER'S MAIDEN NAME Mary R. Storm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) no		16. SOCIAL SECURITY NO none	17. INFORMANT William H. Ryland Address Riverdale, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Sclerosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/14</u> , 1958, to <u>2/24</u> , 1958, that I last saw the deceased alive on <u>2/22</u> , 1958, and that death occurred at <u>Hospital</u> M.D., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>4506 College Ave</i>	
ACTUAL SIGNATURE <i>C. Louis Mendel M.D.</i>		DATE SIGNED <i>2/26/58</i>	
PHYSICIAN'S NAME (Type) <i>C. LOUIS MENDEL</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb 27, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) Colmar Manor, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	24a. REC'D BY REGISTRAR DATE FEB 28 '58
			24b. REGISTRAR'S SIGNATURE <i>C. L. Mendel</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURNAU V. C.

EEB 1979

LIBRARY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2324

## CERTIFICATE OF DEATH

Reg. Dist. No.

112339

1. PLACE OF DEATH o COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		d. STREET ADDRESS <b>6114 Landover road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lucille</b>	First	Middle	Last <b>Samuels</b>	4. DATE OF DEATH <b>Fe B</b>	Month Year Day <b>8 1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August, 11, 1907</b>	9. AGE (In years lost birthday) <b>50 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Librarian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public Library</b>		11. BIRTHPLACE (State or foreign country) <b>New York, N.Y.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Robert Boyd</b>		14. MOTHER'S MAIDEN NAME <b>May C. (unknown)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>135-09-5540</b>		17. INFORMANT Address <b>Ernest Samuels 6114-Landover Rd. Cheverly Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>340.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/18</b> , 1958, to <b>2/8</b> , 1958, that I last saw the deceased alive on <b>2/8</b> , 1958, and that death occurred at <b>11:35</b> A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <b>Norman Donat Pomeau</b> M.D. ADDRESS (Street, city or town, state) <b>3503 Penny St</b> DATE SIGNED <b>2/8/58</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-11-58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Geo. Wash. Memo. Park</b>	
22d. LOCATION (City, town, or county) <b>Paramus</b>		(State) <b>New Jersey</b>		24a. RECEIVED BY REGISTRAR DATE	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Riewerts Memo. Home Bergenfield N. J.</b>		ADDRESS <b>W.W.CHAMBERS CO., Riverdale, Maryland.</b>		24b. REGISTRAR'S SIGNATURE <b>John E. Healy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

REAU V. S.

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REGEV E

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2365 CERTIFICATE OF DEATH

112340

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>P.R. Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>P.R. Georges</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRANDYWINE</b>		c. LENGTH OF STAY IN 1b <b>46 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRANDYWINE</b>		d. STREET ADDRESS <b>MARYLAND</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>GOTT Fred</b>	Middle <b>GodFRED</b>	Last <b>SCHLAFF</b>	4. DATE OF DEATH <b>Feb 12</b>	Month <b>Feb</b>	Day <b>12</b>	Year <b>1958</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>MARCH 22 - 1898</b>	9. AGE (in years, lost birthday) <b>59 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bridge Builder for years to</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GERMANY</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				
13. FATHER'S NAME <b>Frederick Schlaefi</b>		14. MOTHER'S MAIDEN NAME <b>ANNA ROSE LEHMAN</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>ANNA SCHLAEFI same as #2</b>		17. INFORMANT <b>Address</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  K DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b) DUE TO  (c) DUE TO		<i>Cardio Respiratory - renal failure with trauma Secondary Cancerous P. &amp; P. Lesions</i>								19. INTERVAL BETWEEN ONSET AND DEATH <input type="checkbox"/>
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Brandywine MD</b>		20f. (City or town) <b>Brandywine MD</b>		(County) <b>Brandywine MD</b>	(State) <b>MD</b>	
21. I certify that I attended the deceased from <b>7-10</b> , 19 <b>57</b> , to <b>2-19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2-12</b> , 19 <b>58</b> , and that death occurred at <b>11:15 P.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Richard Doban</b> M.D. ADDRESS (Street, city or town, state) <b>Brandywine MD</b> DATE SIGNED										
PHYSICIAN'S NAME (Type) <b>Richard Doban</b>		Brandywine MD								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Feb 15-1958</b>		22b. DATE THEREOF <b>Brandywine MD</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Brandywine MD</b>		(State) <b>MD</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brandywine Brothers 1661 Good Hope Rd.</b>		ADDRESS <b>Brandywine MD</b>		24a. REC'D BY REGISTRAR <b>FEB 14 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. reduced</b>				

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in it should be filed with  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECORDED V. S

FEB 11 1968



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2366 CERTIFICATE OF DEATH

Reg. Dist. No.

102341

1. PLACE OF DEATH e. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>4 yrs. 5 mos. and 8 days.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
3. NAME OF DECEASED (Type or print) <b>Louis</b>		d. STREET ADDRESS <b>1115 Park Road, N. W.</b>	
4. DATE OF DEATH Month <b>2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>Day</b> <b>21</b>	
5. SEX <b>Male</b>		5. COLOR OR RACE <b>White</b>	
6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>8/30/86</b>		9. AGE (in years last birthday) <b>71 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waiter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hammals Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
13. FATHER'S NAME <b>John Scribante</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Gnotta</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-10-6391</b>	
17. INFORMANT <b>Margherita Scribante Decedent's wife</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary emphysema, bilateral</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral arteriosclerosis with Parkinsonism</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p.m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/16</b> , 19 <b>53</b> , to <b>2/24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/21</b> , 19 <b>58</b> , and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Moe Weiss</b> ADDRESS (Street, city or town, state) <b>Glenn Dale Hospital</b> DATE SIGNED <b>2/24/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/25/58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) <b>Bladensburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		ADDRESS <b>3821 - 14th St. N.W. Washington, D.C.</b>	
24a. REC'D BY REGISTRAR <b>DATE FEB 27 1958</b>		24b. REGISTRAR'S SIGNATURE <b>D. L. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician all completely filled in it, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Logs 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. A. V. S.

SEAL

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2230 CERTIFICATE OF DEATH

112342

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland b COUNTY Prince George	
PRINCE GEORGE MARYLAND		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	c. LENGTH OF STAY IN 1b	d. STREET ADDRESS 3334 Chauncey Pl.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First TERESA Middle Scullen		4. DATE OF DEATH Month Feb Day 25 Year 1958	
S SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) N.J.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Scullen		14. MOTHER'S MARRIED NAME Mary McKeown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No, or unknown		16. SOCIAL SECURITY NO. 17. INFORMANT James R Scullen 3334 Chauncy Pl.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 18 months	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO		Congestive heart failure	
(c) DUE TO		arteriosclerotic heart disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 2, 1958, to February 25, 1958, that I last saw the deceased alive on 2/21/58, and that death occurred at 3:45 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Leon Lantsky M.D.		3408 Rhode Island, 44th Avenue, Brooklyn, N.Y. 11225	
PHYSICIAN'S NAME (Type) Leon R. Levitsky		Mt. Rainier, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-28-58	
22c. NAME OF CEMETERY OR CREMATORIAL Holy Sepulchre		22d. LOCATION (City, town, or county) Tolsonway Bronx, N.Y. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home		ADDRESS 4812 Ga Ave NW	
		24a. REC'D BY REGISTRAR M. J. 3 '58	
		24b. REGISTRAR'S SIGNATURE Alphonse	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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1300  
1300

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02343

2268

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George's Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Alexandria</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park Md.</i>		c. LENGTH OF STAY IN 1b <i>43</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Alexandria</i>		d. STREET ADDRESS <i>Adams</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hospital of the Good Samaritan</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>ALBERT</i>	Middle <i>Franklin</i>	Last <i>SEATON</i>	4. DATE OF DEATH <i>7 FEB 25</i>	Month <i>Feb</i>	Day <i>25</i>	Year <i>1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Ag 9 1883</i>	9. AGE (In years lost birthday) <i>74</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>self employed</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FARMER</i>		11. BIRTHPLACE (State or foreign country) <i>67</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>John Seaton</i>		14. MOTHER'S MAIDEN NAME <i>Mrs. Anna Daniels</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>316-12-4414</i>		17. INFORMANT <i>Albert Seaton - College Park Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Saccular Heart Disease</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>(b) Arterio Saccular Heart Disease</i>		DUE TO <i>(c)</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>4113 Berry St.</i>		20f. (City or town) (County) (State) <i>College Park Md.</i>	
21. I certify that I attended the deceased from <i>Dec 24, 1957</i> to <i>7 Feb 1958</i> , that I last saw the deceased alive on <i>Feb 24, 1958</i> , and that death occurred at <i>94 M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Wil. Etienne</i>		ADDRESS (Street, city or town, state) <i>4113 Berry St.</i>		DATE SIGNED <i>27/5/58</i>			
PHYSICIAN'S NAME (Type) <i>Wil. Etienne</i>							
22a. BURIAL, CREMATION, REMOVAL (specify) Burial		22b. DATE THEREOF <i>2/28/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>George Washington</i>		22d. LOCATION (City, town, or county) (State) <i>Hyattsville, Maryland.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Gasch's Sons</i>				ADDRESS <i>Hyattsville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>2/28/58</i>	
						24b. REGISTRAR'S SIGNATURE <i>John J. Etienne</i>	

BUREAU V. L.

103 - 1958



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2325 CERTIFICATE OF DEATH**

Reg. Dist. No. 02344

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover Hills</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		d. STREET ADDRESS <b>4800 Woodlawn Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>John</b>	Middle <b></b>	Last <b>Sheehan</b>	4. DATE OF DEATH <b>Feb. 28 1958</b>	Month <b>Feb.</b>	Day <b>28</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>69 yrs</b>	9. AGE (In years last birthday) <b>69 yrs</b>	IF UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS Days <b></b>	Hours <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Wash D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John F. Sheehan</b>		14. MOTHER'S MAIDEN NAME <b>Brigdet Scanlon</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hosp. Records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>441X</b>		DUE TO <b>Brachopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 1958, to <b>Feb</b> , 1958, that I last saw the deceased alive on <b>28 Feb 1958</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Thomas G. Maloney M.D.</b>		ADDRESS (Street, city or town, state) <b>4814 - 71st Ave, Landover Hills, Md.</b>		ADDRESS (Street, city or town, state) <b>4814 - 71st Ave, Landover Hills, Md.</b>		DATE SIGNED <b>28/2/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-1-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Maloney</b> <b>Funeral Home</b>		ADDRESS <b>3831 Ga. Ave. N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>R. J. Smith</b>	

BUREAU V. 2

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12345

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Prince Georges MARYLAND		a. STATE Maryland	b. COUNTY Pr. Geo.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) m Bowie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
c. LENGTH OF STAY IN lb D. O. A.		d. STREET ADDRESS 4919 40th Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bowie Race Track Dispensary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Charles	Middle Malone
		Last Shryock	4. DATE OF DEATH 5 AM Feb. 24
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH 7-28-97	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Theophilus Shryock		14. MOTHER'S MAIDEN NAME Kate Malone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address Charles M. Shryock, Jr. College Park, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (b) DUE TO Cardiovascular renal disease (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL/DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
		24a. REC'D BY REGISTRAR DATE MAR 3	
		24b. REGISTRAR'S SIGNATURE	

BRUNSWICK V. S.

173

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

62346

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA3. Page 5 may be retained by our files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH  
a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Riverdale

c. LENGTH OF STAY IN lb

D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Leland Memorial Hospital

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Howard

Martin

Shupp

5. SEX

6. COLOR OR RACE

Male

white

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Plasterer

7. MARRIED  NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

Sept 1, 1900

57

yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

4. DATE  
OF  
DEATH

February 17

Day

19

Year

58

13. FATHER'S NAME

Fred Shupp

14. MOTHER'S MAIDEN NAME

Annie Castle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 17. INFORMANT

Address

Esther Shupp; same address as # 2.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

440-1

DUE TO

Acute congestive heart failure

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Cardiovascular renal disease

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH.

20c. TIME OF INJURY  
Hour a. m.  
p. m.

Month, Day, Year  
19

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  
White  
at work  Not white  
at work

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

John T. Maloney, M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

February 17, 1958

22a. BURIAL, CREMATION  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Feb. 20, 1958

22c. NAME OF CEMETERY OR CREMATORIUM

Greenwood Cemetery

22d. LOCATION (City, town, or county)

Laurel, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

DATE FEB 24 '58

24b. REGISTRAR'S SIGNATURE

G. J. - 2-4-58

BUREAU V.

FEB 24 1959

U.S. GOVERNMENT  
PRINTING OFFICE: 1959  
14-3516

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film G225, 2/11/58

2368

## CERTIFICATE OF DEATH

112347

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE			
PRINCE George, MARYLAND		Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY			
RURAL Selisa					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Selisa				
	d. STREET ADDRESS 8032 - New Fort Washington				
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First	Middle	Last		
MYRTLE			Silbaugh		
4. DATE OF DEATH	Month	Day	Year		
	FEB	- 2	- 1958		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
F	W		12 July 1874	83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Morgantown, W. Va	
12. CITIZEN OF WHAT COUNTRY?		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Unknown		Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <small>If yes, give war or dates of service)</small>		16. SOCIAL SECURITY NO		17. INFORMANT	
				Address Bertha Snyder 8032 N. Ft. Wash Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					
442.1 DUE TO Pneumonia (Bronchial) 3 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) congestive failure 3 months					
DUE TO (c) arteriovenous fistula unknown					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
442.1 Parkinsons disease					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I attended the deceased from May 22, 1956, to Feb 2, 1958, that I last saw the deceased alive on Feb 2, 1958, and that death occurred at 11:50 AM, from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE H. G. Hadley		M.D.			
PHYSICIAN'S NAME (Type) Dr. H. G. Hadley		1252 - 6th St., S. W. Washington, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Shipped to on 2/3/58		22c. NAME OF CEMETERY OR CREMATORIUM Lafayette Memorial Park	
BURNING				22d. LOCATION (City, town, or county) Brownsville Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR FEB 5 '58	
Kirkland's Funeral Home 816 H St. NW D.C.				24b. REGISTRAR'S SIGNATURE W. L. Leach	

MAURAU V. S.

GEI VED

1  
FOR STATE  
HEALTH DEPT.  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

112348

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by our files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Southland</u>		d. LENGTH OF STAY IN 1B <u>7 months</u>	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4645 - Lewis Ave</u>		d. STREET ADDRESS <u>4645 - Lewis Ave</u>	
3. NAME OF DECEASED (Type or print)		e. DATE OF DEATH Year <u>Feb 12 1958</u>	
3. NAME OF DECEASED First <u>Agnes</u> Middle <u>Teresa</u> Last <u>Slattery</u>		f. DATE OF BIRTH <u>Oct 21, 1901</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home District of Columbia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Enos Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>143-12-1234</u> 17. INFORMANT <u>Joseph P. Slattery</u> Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> DUE TO <u>440 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Same as above</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a.m. <input checked="" type="checkbox"/> p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Baltimore</u> (County) <u>Baltimore</u> (State) <u>Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		DATE SIGNED <u>Feb. 12, 1958</u>	
22a. BURIAL-CREMATION DATE THEREOF REMOVAL (Specify) <u>Funeral - 13-58</u>		22b. NAME OF CEMETERY OR CREMATORIAL <u>Imperial Olivet</u>	
22c. ADDRESS <u>131-1118</u>		22d. LOCATION (City, town, or county) <u>Washington D.C.</u> (State) <u>D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert D. Mattingly</u>		24a. REC'D BY REGISTRAR DATE <u>Feb. 13, 1958</u>	
		24b. REGISTRAR'S SIGNATURE <u>Robert D. Mattingly</u>	

210000

8, 1959.

Map 25° 1'

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2370

## CERTIFICATE OF DEATH

Reg. Dist. No.

112349

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Radiant Valley</i>		c. LENGTH OF STAY IN 1b RURAL and give nearest town	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6808-Shepherd Street</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Radiant Valley</i>	
f. STREET ADDRESS <i>6808-Shepherd Street</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First. <i>Helen</i>	Middle <i>Emily</i>	Last <i>Smith</i>
4. DATE OF DEATH	Month <i>Feb.</i>	Year <i>1958</i>	
5. SEX	6. COLOR OR RACE <i>Female white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 3 1896</i>
9. AGE (In years lost birthday) yrs. <i>61</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife at home</i>	11. KIND OF BUSINESS OR INDUSTRY <i>New Jersey</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Joseph Woolley</i>	14. MOTHER'S MAIDEN NAME <i>Annie E. Tilton</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>Charles A. Smith Esq. ABCVE</i>
17. INFORMANT <i>Charles A. Smith Esq. ABCVE</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>581.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Cirrhosis of liver</i> (b) DUE TO (c)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	INTERVAL BETWEEN ONSET AND DEATH <i>3 wks.</i> <i>4 yrs.</i>
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. p. p. m.	Month <i>19</i>	Day <i>19</i>	Year <i>1958</i>
20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>2409 Varum St.</i>	20f. (City or town) <i>Lodover Hills, Md.</i>	(County) <i>Baltimore</i>
21. I certify that I attended the deceased from <i>1953</i> , 19, to <i>2/12</i> , 1958, that I last saw the deceased alive on <i>2/16</i> , 1958, and that death occurred at <i>1:05 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>F.E. Muser</i>	PHYSICIAN'S NAME (Type) <i>F.E. Muser</i>	ADDRESS (Street, city or town, state) <i>2409 Varum St. Lodover Hills, Md.</i>	DATE SIGNED <i>2/17/58</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/19/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rally's Funeral Home, Mt. Rainier, Md.</i>	ADDRESS <i>Mt. Rainier, Md.</i>	24a. REC'D BY REGISTRAR <i>Feb 20 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. J. Heuer</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retched by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRUNSWICK

EB 123



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2327 CERTIFICATE OF DEATH

Reg. Dist. No.

112350

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>PRINCE GEORGE'S</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>		c. LENGTH OF STAY IN 1b <b>14 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COLLEGE PARK</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>		e. STREET ADDRESS <b>5003 SHAN PLACE</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>MYRTLE</b>		First	Middle	Last	4. DATE OF DEATH <b>FEB 2 1958</b>	Month	Day	Year
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>2 MAY 1902</b>	9. AGE (In years last birthday) <b>55 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 MRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Church, Va.</b>		
13. FATHER'S NAME <b>William H. Palmer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Joseph Sherwood</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Lois Stover, 2403 Strorm Dr., Falls Church, Va.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Adenocarcinoma of the Stomach</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)      (State)		
21. I certify that I attended the deceased from <b>19 Jan 1958</b> to <b>2 Feb 1958</b> , that I last saw the deceased alive on <b>2 Feb 1958</b> , and that death occurred at <b>7:15 AM</b> , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <b>Arlington, Va.</b>
ACTUAL SIGNATURE <i>Donald W. Mitchell</i>				DATE SIGNED				
PHYSICIAN'S NAME (Type) <b>DR. DONALD W MITCHELL MD</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 5, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Columbia Gardens</b>		22d. LOCATION (City, town, or county) <b>Arlington, Va.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Green Funeral Home</b>		ADDRESS <b>Arlington, Va.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Smith</b>		

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2328 CERTIFICATE OF DEATH

112351

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>P.G.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>		c. LENGTH OF STAY IN 1b <b>RURAL and give nearest town)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham Md.</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		8 Days		Route # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Paul</b>	Middle <b>E</b>	Last <b>Soucie</b>	4. DATE OF DEATH	Month <b>Feb. 16</b>	Day <b>19</b>	Year <b>58</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH <b>Jan. 27th, 1908</b>	9. AGE (In years last birthday) <b>50</b> yr.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Hours <b>0</b>
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>American Cab Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Manteno, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David Joseph Soucie</b>		14. MOTHER'S MAIDEN NAME <b>Cordelia Beaupre</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>WW 1</b>	17. INFORMANT <b>Myrtle A. Soucie, Box #168A, Route # 2</b>	Address <b>Lanham, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>540.1</b>		<b>Toxemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Peritonitis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>			
(c) DUE TO <b>Ruptured Gastric Ulcer</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>
21. I certify that I attended the deceased from <b>2/18/58</b> , 19, to <b>2/19/58</b> , 19, that I last saw the deceased alive on <b>2/18/58</b> , 19, and that death occurred at <b>9:30 AM</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>W.M.P. Holbrook M.D. 4500 College Ave. College Park, Md. 20740</b>	
ACTUAL SIGNATURE <b>W.M.P. Holbrook</b>						DATE SIGNED <b>2/19/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Holbrook</b>							
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/19/1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington Nat'l Cem.</b>	22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter L. HUMMERS</b>	ADDRESS <b>Co. Rivendale</b>	24a. REC'D BY REGISTRAR <b>Feb 20 58</b>	24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	DATE			

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2329 CERTIFICATE OF DEATH**

U2352

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md</b>		c. LENGTH OF STAY IN lb <b>19 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bellemead. xx</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>			/d STREET ADDRESS <b>7302 Parkwood Drive</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First <b>Ralph R.</b>	Middle <b>Staples</b>	Lost	4. DATE OF DEATH <b>Feb. 21 1958</b>	Month Day Year	Day 21 19 58
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-21-10</b>	9. AGE (In years less than 18 years <b>47</b> ) yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Repairman-Gagant Shaw</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Washer Repairing</b>			10c. BIRTHPLACE (State or foreign country) <b>Pleasant Grove, Md.</b>
13. FATHER'S NAME <b>Wm. R. Staples</b>			14. MOTHER'S MAIDEN NAME <b>Harriet C. Reid</b>			12. CITIZEN OF WHAT COUNTRY?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT <b>Wilma Staples (Wife) Same as above</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PORTAL CIRRHOSIS</b> DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>BRONCHIOGENIC CARCINOMA RT. BRONCHUS</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>3303 PERRY ST.</b>	(County) <b>MT. RAINIER, MD.</b>	(State) <b>2-21-58</b>
21. I certify that I attended the deceased from <b>2/21/1958</b> to <b>2/21/1958</b> , that I last saw the deceased alive on <b>2/21/1958</b> , and that death occurred at <b>9:54 A.M.</b> from the causes and on the date stated above.						
ADDRESS (Street, city or town, state) <b>3303 PERRY ST.</b> DATE SIGNED <b>2-21-58</b>						
ACTUAL SIGNATURE <b>William B. Hagan</b> M.D.						
PHYSICIAN'S NAME (Type) <b>Dr. William Hagan</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/21/58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) <b>Prince Georges County, Md.</b>	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. H. Kinner Co. 2901-14th ST. NW, WASH, D.C.</b>			ADDRESS <b>D.C.</b>	24a. REC'D. BY REGISTRAR <b>FEB 24 '58</b>	24b. REGISTRAR'S SIGNATURE <b>D. L. Smith</b>	

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FEB 24 1958

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2371 CERTIFICATE OF DEATH**

Reg. Dist. No.

02354

1. PLACE OF DEATH a. COUNTY <b>Prince George County MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Allentown</b>	c. LENGTH OF STAY IN lb <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Allentown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5870 Allentown Road S. E.</b>	e. STREET ADDRESS <b>5807 Allentown Road S.E.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JACKIE LEE THOMAS</b>	First <b>JACKIE</b>	Middle <b>LEE</b>	Last <b>THOMAS</b>
4. DATE OF DEATH <b>February 5, 1958</b>	Month <b>February</b>	Day <b>5</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARITAL STATUS <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>Sept. 3, 1957</b>
9. AGE (In years last birthday) <b>5 yrs.</b>	10. IF UNDER 1 YEAR Months <b>5</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Hours <b>0</b>
13. FATHER'S NAME <b>Houston H. Thomas</b>	14. MOTHER'S MAIDEN NAME <b>Shirley Woods</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Houston H. Thomas,</b>	Address <b>5870 Allentown Road., S.E., Wash. 22, DC.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.  (b) <b>Hydrocephalus</b>  (c) <b>Spina Bifida &amp; Meningocele</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>5"</b>  <b>4 months</b>  <b>5 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9/1</b> , 1957, to <b>2/15</b> , 1958, that I last saw the deceased alive on <b>2/15</b> , 1958, and that death occurred at <b>4551</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Houston H. Thomas</i>	M.D.	ADDRESS (Street, city or town, state) <b>4400 Bowen Road S. E., Wash. 22, D.C.</b>	DATE SIGNED <b>Feb 2/15/58</b>
PHYSICIAN'S NAME (Type) <b>T. THOMAS F. CULLEN</b>	22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Feb. 10, 1958</b>		
22b. DATE THEREOF <b>Feb. 10, 1958</b>	22c. NAME OF CEMETERY OR INCINERATOR <b>Arlington National</b>	22d. LOCATION (City, town, or county) <b>Arlington, Virginia.</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO., 517 11th St., S.E.,</b>	ADDRESS <b>Wash. D.C.</b>	24a. REC'D. BY REGISTRAR <b>FEB 11 1958</b>	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU N.Y.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2372

## CERTIFICATE OF DEATH

02355

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>		c. LENGTH OF STAY IN lb <b>36 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>		d. STREET ADDRESS <b>Enterprise Road, Route #1</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Enterprise Road, Route #1</b>				d. STREET ADDRESS <b>Enterprise Road, Route #1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>James</b>		First	Middle	Lost	4. DATE OF DEATH <b>Franklin Thompson</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 3rd, 1872</b>	9. AGE (In years last birthday) <b>85 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith &amp; Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Washington Giles Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Gusta Marma Duke</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Frances L. Robertson, 2017 Quincy St. N.E.,</b>		Address <b>Wash. DC</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Generalized Arteriosclerotic Disease.</b>		DUE TO <b>Senile.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week.</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Generalized Arteriosclerotic Disease.</b>		DUE TO <b>Senile.</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month Day Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from <b>Feb. 19, 1958</b> to <b>Feb. 22, 1958</b> , that I last saw the deceased alive on <b>Feb. 19, 1958</b> , and that death occurred at <b>10:25 A.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>2/23/58</b>		
ACTUAL SIGNATURE <b>H. James Kydel M.D.</b>								
PHYSICIAN'S NAME (Type) <b>H. James Kydel</b>								
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 26, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Hart Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>		ADDRESS		24. REC'D BY REGISTRAR REGISTRATION SIGNATURE <b>W.W. Chambers</b>		DATE FEB 26 '58		

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1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

112356

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>24 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		X <b>Seat Pleasant</b> d. STREET ADDRESS <b>305 69th Place</b>	
3. NAME OF DECEASED (Type or print) <b>Josephine</b>		e. DATE OF DEATH <b>February 5, 1958</b>	
3. SEX <b>Female</b>		f. AGE (In years at birthday) <b>84 yrs</b>	
6. COLOR OR RACE <b>white</b>		g. DATE OF BIRTH <b>8-13-73</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		10. KIND OF BUSINESS OR INDUSTRY <b>11. BIRTHPLACE (State or foreign country) Washington, D.C.</b>	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Name</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Scala</b>	
13. FATHER'S NAME <b>Joseph Arth Thorne</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT</b> <b>Madeline F. Thorne; same address as # 2.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) <b>7040</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c) Fracture of right femur	
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>12, 1958, 1-12-58</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fall in home</b>	
20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> or work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Seat Pleasant, Pr. Geo. Md.</b>		(County) <b>Baltimore</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 7-58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>washington national</b>		22d. LOCATION (City, town, or county) <b>Bethesda, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Maloney</i>		24a. REC'D BY REGISTRAR <b>FEB 6 '58</b>	
ADDRESS <b>Summer Bros 1661 - 4th Street NW Wash DC</b>		24b. REGISTRAR'S SIGNATURE <i>John T. Maloney</i>	

BUREAU, V. S.

1958

SEARCHED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

102357

2373

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 6631- Bedford Lane S.E.	
3. NAME OF DECEASED (Type or print) NETTIE		First	Middle THORNE
		Last	4. DATE OF DEATH Feb. 7th, 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Jan. 16 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Josiah Taylor		14. MOTHER'S MAIDEN NAME Catherine Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Pearl V. Thorne Same as # 2.
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Bronchitis &amp; Asthma</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1947, 1947, to her death, 1958, that I last saw the deceased alive on 2-7-1958, and that death occurred at 12:25 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Malcolm Lent</u>		ADDRESS (Street, city or town, state) <u>Washington D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Malcolm Lent</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 8-1958	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Bros</u>		1661- ADDRESS Good Hope Rd. S. E. Washington, D.C.	24a. REC'D BY REGISTRAR DATE FEB 10 1958
		24b. REGISTRAR'S SIGNATURE <u>John Edwards</u>	

FBI WILMINGTON  
BUREAU NO. 5

FEB 10 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02358

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2331			Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY      Prince Georges      MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland      b. COUNTY Pr. Geo			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      Cheverly      D.O.A.			c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)      Prince Georges General Hospital			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      West Lanham Hills			
f. STREET ADDRESS 4907- 78th Avenue			g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
			h. DATE OF DEATH Lost      Month February      Day 1st,      Year 1958			
i. NAME OF DECEASED (Type or print)      Peter      Hans      Trave			j. AGE (In years from birthday)      35 yrs.			
k. SEX      Male      white			l. IF UNDER 1 YEAR      Months 0      Days 0      Hours 0      Min. 0			
m. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)      Superintendent			n. 10b. KIND OF BUSINESS OR INDUSTRY      Civil Service			
o. 11. BIRTHPLACE (State or foreign country)			p. 12. CITIZEN OF WHAT COUNTRY?      U.S.A.			
q. 13. FATHER'S NAME      Unknown			r. 14. MOTHER'S MAIDEN NAME      Gertrude Myer			
s. 15. WAS DECEASED EVER IN U. S. ARMED FORCES?      Yes      W.W. 2			t. 16. SOCIAL SECURITY NO.      Address			
u. 17. INFORMANT			v. Mrs. Peter Trave; same address as # 2.			
w. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			x. INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)      Hemorrhage and shock			y. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
z. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.      (b)      Hemorrhage and shock			z. DUE TO Crushed chest and abdomen			
aa. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						
ab. 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			ac. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of an automobile in collision with a bus.			
ad. 20c. TIME OF INJURY      Month, Day, Year 5:45 p.m. 2-1-58 19			ae. 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> Highway			
af. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			ag. 20f. (City or town)      (County)      (State) Washington, D.C.			
ah. 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ai. ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type)      John T. Maloney, M.D.			aj. DATE SIGNED <i>John T. Maloney</i>			
ak. 22a. BURIAL CREMATION REMOVAL (Specify)      Cremation			al. 22b. DATE THEREOF      2/4/58			
			am. 22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Crematory			
			an. 22d. LOCATION (City, town, or county)      Colmar Manor, Md.			
			ao. 24a. REC'D BY REGISTRAR      DATE 2/3 '58			
			ap. 24b. REGISTRAR'S SIGNATURE <i>John T. Maloney</i>			
ap. 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Gasch's Sons Hyattsville Md.						

СЕМЬЯ В. С.

ДЕЛАЕТ

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2374

## CERTIFICATE OF DEATH

112359

Reg. Dist. No.

1. PLACE OF DEATH  
o COUNTY

PRINCE GEORGES

MARYLAND

## b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

District Heights

c. LENGTH OF STAY IN 1b  
OR INSTITUTION

2818 Gateway Blvd.

3. NAME OF  
DECEASED  
(Type or print)

Erastus J.

First

Middle

Last

4. DATE  
OF  
DEATH

Travers

Feb 27

1958

## 5. SEX

Male

## 6. COLOR OR RACE

white

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

Nov 28, 1871 86

9. AGE (in years  
from birth)  
yrs10. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Bricklayer

Same

## 11. KIND OF BUSINESS OR INDUSTRY

team

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Charles P. Travers

## 14. MOTHER'S MAIDEN NAME

Corieilia Van Story

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

no

## 16. SOCIAL SECURITY NO.

none

## 17. INFORMANT

Mr. Anne S. Travers - District Hts., Md.

Address  
7818 Gateway Blvd.,  
District Hts., Md.

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a)

acute heart failure

INTERVAL BETWEEN  
ONSET AND DEATH  
2 days 15Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

## DUE TO

(b) arterio sclerotic heart disease  
(c) with decompensation

## DUE TO

## (c)

## MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20c TIME OF INJURY  
Hour o. m. 9 a.m.  
p. m. 2 p.m.Month 19  
Day 27  
Year 195820d. INJURY OCCURRED  
While at work  Not while at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)20f. (City or town)  
(County)

(State)

21. I certify that I attended the deceased from \_\_\_\_\_, 1958, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased  
alive on \_\_\_\_\_, 1958, and that death occurred at \_\_\_\_\_ AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATUREBenjamin S. Peeson M.D. 7711 Mason St. DISTRICT HEIGHTS  
2-27-58PHYSICIAN'S  
NAME (Type)

BENJAMIN S. PESON M.D. MARYLAND

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

3-3-58

## 22c. NAME OF CEMETERY OR CREMATORIUM

Cedar Hill

## 22d. LOCATION (City, town, or county)

(State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

All Funeral Home - Wm. H. Wm. H. Wm. H.

BUREAU V.

113

155 VILLE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2332

## CERTIFICATE OF DEATH

Reg. Dist. No. 02360

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>		b. COUNTY <b>Prince Georges</b>	
c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		d. STREET ADDRESS <b>1994 37th Place</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Charles</b>	Middle <b></b>	Last <b>Travis</b>
4. DATE OF DEATH <b>2 14 1958</b>	Month <b>2</b>	Day <b>14</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-4-08</b>
9. AGE (In years last birthday) <b>49 50 yrs</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sanitary Commissioner</b>	11. KIND OF BUSINESS OR INDUSTRY <b>Bookkeeper</b>	12. BIRTHPLACE (State or foreign country) <b>Missouri</b>
13. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	14. MOTHER'S MAIDEN NAME <b>Bertha E Levermann</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or Unknown) <b>Yes</b>	16. SOCIAL SECURITY NO <b>234 03 9865</b>	17. INFORMANT <b>Marquard G Travis</b>	Address <b>Hyattsville, Maryland.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>34x</b> IMMEDIATE CAUSE (a) <i>Beeri</i> <i>obcess</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2-11, 1958</b> , to <b>2-14, 1958</b> , that I last saw the deceased alive on <b>2-14, 1958</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <i>A. Reit</i>		ADDRESS (Street, city or town, state) <b>4314- GALLATIN ST.</b>	
PHYSICIAN'S NAME (Type) <b>AARON REITZ, M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb 18, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 2-14-58</b>	24b. REGISTRAR'S SIGNATURE <i>Minerick</i>

BUNDESKUNSTSAMMLUNG

FEB 18 1958

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

112361

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and if necessary within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. STATE c. COUNTY	
2333 Prince Georges MARYLAND		2333 Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cheverly		Brentwood Heights	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
3 hrs		7100 Belwood Street	
NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Prince George's General Hospital			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Charlotte Virginia Tutz		Month	Day
Middle		Year	
Last		2	15
5. SEX		6. COLOR OR RACE	
Female White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 2-6-26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Clerk			
11. BIRTHPLACE (State or foreign country)		9. AGE (in years last birthday)	
Colorado		32 yrs.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Clifford Mantor		Vivian Holland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For men only) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
no		17. INFORMANT	
		Joseph R. Tutz Jr. Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
976X		Hemorrhage and shock	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Gun shot wound of head	
(b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
75 hours o. m. 2-15-58		Shot self in head	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	
House		Brentwood P.S. MD	
(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
James I. Boyd		DATE SIGNED 2-15-58	
22a. BURIAL CREMATION, DATE THEREOF REMOVAL (Specify)		22b. NAME OF CEMETERY OR CREMATORIAL	
Burial Feb 18-58		Cedar Hill	
22d. LOCATION (City, town, or county) (State)			
Southland Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 19 1958	
Survivor Bros 1661 Good Hope Rd & 8th Street		24b. REGISTRAR'S SIGNATURE	

LIBRARY V. 8

EB 18 1959

**FOR STATE  
HEALTH DEPT.**  
**K**  
**TO FUNERAL DIRECTOR:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12362

Reg. Dist. No.

2334

Item 7 File # 226 3-3-58 et

1 PLACE OF DEATH  
a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

5702 Chillum Heights Drive

c. LENGTH OF STAY IN TB

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince Georges General Hospital

7

13

3

NAME OF  
DECEASED  
(Type or print)

First

Middle

Edna Mae Waddy

5

SEX

6 COLOR OR RACE

7 MARRIED

 NEVER MARRIED 8 DATE OF BIRTH

Female

WIDOWED

DIVORCED

7-15-25

10a

USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b

KIND OF BUSINESS OR INDUSTRY

11

BIRTHPLACE (State or foreign country)

12

CITIZEN OF WHAT COUNTRY?

Housewife

13

FATHER'S NAME

Willie Felton

15

WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

(If yes, give war or dates of service)

16

SOCIAL SECURITY NO

17

INFORMANT

No

18

CAUSE OF DEATH

[Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

550.1

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Septicemia

Generalized peritonitis

Ruptured appendiceal abscess

INTERVAL BETWEEN  
ONSET AND DEATH

19

WAS AUTOPSY

PERFORMED?

YES NO 

MEDICAL CERTIFICATION

20a

EXTERNAL CAUSE WAS

PRIMARY  or CONTRIBUTING 

CAUSE OF DEATH.

20b

DESCRIBE HOW INJURY OCCURRED

(Enter nature of injury in Part I or Part II of item 18)

20c

TIME OF INJURY

Month, Day, Year

Hour

o. m.

p. m.

19

20d

INJURY OCCURRED

While

of work

Not while

of work

</div

BUREAU V.

1973



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2375

## CERTIFICATE OF DEATH

112363

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE Maryland b. COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Villa Heights Md	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Villa Heights, Md.			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3818 58th avenue	d. STREET ADDRESS 3818 58th avenue,		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First Isabella May Walker	Middle	Last	4. DATE OF DEATH Month Feb 6, 1958- Day 19 Year		
5 SEX female	6. COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 1, 1875	9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months 0 Dofs 0 Hours 0 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Henry Grisinger		14. MOTHER'S MAIDEN NAME ? Irvin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Vincent G. Walkendifer Villa Heights Md.	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Bronchitis pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		Generalized arteriosclerosis		year	
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Allergy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1st, 1958, to Feb 6th, 1958, that I last saw the deceased alive on Feb 6th, 1958, and that death occurred at 1 P.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE T.L. BURGMAN				DATE SIGNED Feb 6, 1958	
PHYSICIAN'S NAME (Type) T.L. BURGMAN				HYATTSVILLE MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 3/10/58		22c. NAME OF CEMETERY OR CREMATORIUM Farrashan Cemetery	
22d. LOCATION (City, town, or county) Far away Pa					
23. FUNERAL DIRECTOR'S SIGNATURE F. L. Isaacs Son		ADDRESS Hyattsville Md		24e. REC'D BY REGISTRAR DATE FEB 11 '58	
				24f. REGISTRAR'S SIGNATURE	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in before the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SAUVEAU V.

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REGGAE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12364

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHA3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal; and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission]		Reg. Dist. No.	
Prince George's		MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY	
Cheverly		Dead on arrival X		Prince George's	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS FES DEN E ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Prince George's General Hospital		5436		X 1005 Oxon Hill Road	
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH
Uriah					February 17 1958
5. SEX		6. COLOR OR RACE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH
Male		Colored	<input checked="" type="checkbox"/> Married	<input type="checkbox"/> Widowed	February 24, 1891 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer		Retired		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
James Wallace		Clora Jones		U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				Mary P. Wallace, same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.1 DUE TO Acute congestive heart failure					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cardiac hypertrophy, atherosclerotic heart disease,					
(c) DUE TO auricular fibrillation, congestive failure					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
19					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James I. Boyd</i>		DATE SIGNED February 17, 1958			
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL/CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 2-22-1958	22c. NAME OF CEMETERY OR CREMATORIUM Church Cemetery		22d. LOCATION (City, town, or county) Oxon Hill, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE John T. Phines & Co. 901		ADDRESS 3rd St., S. W.	24a. REC'D BY REGISTRAR DATE FEB 21 '58		24b. REGISTRAR'S SIGNATURE <i>John T. Phines &amp; Co.</i>

BUNNU Y. S

REB 24-52

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2336 CERTIFICATE OF DEATH**

Reg. Dist. No. 112365

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>2 Mos 21 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XBXXXXXX Naylor X</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>Box 79 a</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Joan Marie</b>	Middle <b>Windsor</b>	Last	4. DATE OF DEATH <b>Feb. 19</b>	Month Day Year <b>19 58</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>10-29-57</b>	9. AGE (in years last birthday) yrs <b>3</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>21</b> Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Preston Windsor</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Richardson</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <b>No</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Mrs. Lillian Richardson Windsor: Item 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1573</b>		RENAL FAILURE		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CONGENITAL NEPHROSIS</b>		DUE TO (c)		3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>—</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>9</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	
20f. (City or town) <b>—</b>		(County) <b>—</b>		(State) <b>—</b>	
21. I certify that I attended the deceased from <b>1/1</b> , 19 <b>58</b> , to <b>2/19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/18/58</b> , 19 <b>58</b> , and that death occurred at <b>12:20 P.M.</b> from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <b>388 Montrose Ave., Laurel, Md.</b>					
DATE SIGNED <b>Albert J. Modlin M.D.</b>					
ACTUAL SIGNATURE <b>Albert J. Modlin</b>		PHYSICIAN'S NAME (Type) <b>ALBERT J. MODLIN</b>		M.D. 388 Montrose Ave., Laurel, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/22/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Carmel Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Upper Marlboro, Md.</b>		(State) <b>—</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pitts Bros - Upper Marlboro, Md.</b>		ADDRESS <b>—</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 25 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>	

CHILAU V. S

1228



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 2337 CERTIFICATE OF DEATH

02366

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>17 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>		d. STREET ADDRESS <b>8403 Patuxent Ave.</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First <b>Carl</b>	Middle <b>(NMN)</b>	Last <b>Worch</b>	4. DATE OF DEATH <b>Feb. 2 1958</b>	Month	Day	Year								
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-2-91</b>	9. AGE (In years lost birthday) <b>66 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Hours	12. IF UNDER 24 HRS Min								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman--Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Piano Business</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
13. FATHER'S NAME <b>Hugo Worch</b>				14. MOTHER'S MAIDEN NAME <b>Ida Haberecht</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>WW 1</b>		16. SOCIAL SECURITY NO <b>578-09-4596</b>		17. INFORMANT <b>Ada Worch</b>		Address <b>8403 Patuxent Ave., College Park, Md.</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>199.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>Brain tumor at Parietal</b> <b>Osteoblastoma</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <b>2/9</b> , 19 <b>49</b> , to <b>2/12</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/2</b> , 19 <b>58</b> , and that death occurred at <b>4:25 P.M.</b> from the causes and on the date stated above.															
ADDRESS (Street, city or town, state) <b>4506 College Ave., College Pk.</b>															
DATE SIGNED <b>2/3/58</b>															
ACTUAL SIGNATURE <b>L. Louis Mendel</b>															
PHYSICIAN'S NAME (Type) <b>Dr. C. Louis Mendel</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>2/5/1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington Nat'l Cem.</b>		22d. LOCATION (City, town, or county) <b>Arlington, Va.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>								24a. REC'D BY REGISTRAR <b>FEB 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Chambers</b>					

RUMEAU V. S.

FEB 6 1973

KELLOGG COMPANY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

112367

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		2338										Reg. Dist. No.					
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)															
a. COUNTY		a. STATE Maryland b. COUNTY Pr. Geo.															
Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)															
		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS															
Cheverly		25 Riverdale															
c. LENGTH OF STAY IN lb		6307 Baltimore Avenue															
D.O.A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)																	
Prince Georges General Hospital																	
EXCELSIOR W.H.																	
e. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year			
John		Joseph		Wright		February		7,		19		58					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years from birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		February 8, 1876		81 yrs.		Months		Days		Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?											
Retired bottler		Coca Cola Co.		Washington, D.C.		U.S.A.											
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME															
John Wright		Unknown															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown]		16. SOCIAL SECURITY NO.		17. INFORMANT		Address											
[If yes, give war or dates of service]		579-03-3149		May Virginia Wright; same address as # 2.													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute congestive heart failure															
442X																	
DUE TO																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Cardiovascular renal disease													
DUE TO		(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
Hour a. m. p. m.		19		While or work <input type="checkbox"/> Not white or work <input type="checkbox"/>													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		John T. Maloney, M.D.										DATE SIGNED					
EXAMINER'S NAME (Type)																	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)									
Burial		2-11-58		Mt. Lincoln		Bellevue		Maryland									
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE											
Till Funeral Home - Wash. D.C.						FEB 10 '58		John T. Maloney									
VS. A15ME																	
SM 2/57																	

RECEIVED  
FEB 10 1958

BUREAU V. S.

RECEIVED  
FEB 10 1958

RECEIVED  
FEB 10 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

112365

**FOR STATE  
HEALTH DEPT.**

**O DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.

**O FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15MB  
3M 2/57

Reg. Dist. No.

1. PLACE OF DEATH 0. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Prince Georges MARYLAND		0. STATE North Carolina BUNCOMBE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b>		c. LENGTH OF STAY IN lb <b>1 month</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2450 Oxon Road</b>		e. 15 RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Annie May York</b>		d. STREET ADDRESS <b>133 Jonestown Road</b>	
First <b>Annie</b>		Middle <b>May</b>	Last <b>York</b>
3. NAME OF DECEASED (Type or print) <b>Annie May York</b>		4. DATE OF DEATH Month Day Year <b>Feb 20 1958</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 9, 1891</b>	
9. AGE (In years last birthday) <b>66 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>0 months 0 days 0 hours 0 min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housenwife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. - E</b>	
13. FATHER'S NAME <b>Bill</b>		14. MOTHER'S MAIDEN NAME <b>Roy James Whittemore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT Address <b>Oliver Lee York, same as #1</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442 X</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO <b>Acute congestive heart failure</b>			
DUE TO <b>Cardiovascular renal disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		DATE SIGNED <b>Feb 20, 1958</b>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL/CREMATION: REMOVAL (Specify) <b>Burial - Removal</b>		22b. DATE THEREOF <b>2/21/58</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>West Memorial Park</b>		22d. LOCATION (City, Town, or county) <b>Weaverville, N. Carolina</b>	
(State)		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. Washington D.C.</b>		24a. ADDRESS <b>517-17th St. by L.E.</b>	
		24b. REC'D BY REGISTRAR <b>DATE FEB 24 '58</b>	
		24c. REGISTRAR'S SIGNATURE <b>Albertson</b>	

BUREAU V.

FEB 24 1959

RECEIVED